



Benefits Booklet

Mayo Medicare Supplement — January 2026

Medical Claims Administered by MMSI, Inc. dba
Medica Health Plan Solutions (Medica)

Pharmacy Claims Administered by Alluma™

COMPONENT OF THE MAYO MEDICAL PLAN

Offered under the Mayo Clinic Health and Welfare Benefits Plan



MAYO MEDICARE SUPPLEMENT BENEFITS BOOKLET

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MAYO CLINIC IN ARIZONA, FLORIDA AND ROCHESTER

JANUARY 1, 2026

Mayo Clinic believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at HR Connect **507 - 266-0440**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or Dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

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

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Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

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Lao/ ລາວ: ຂໍຄວາມເອົາໃລ້ວ: ຖ້າທ່ານເວົ້າພາກສາລາວ, ລາມີປໍ່ວິການລ່ວຍດ້ານພາກສາແບບບໍ່ແສລຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ລາມີຄໍ້ອງຊ່ວຍເສີມ ແລະ ບໍ່ວິການແບບທີ່ເປົ້າມາເຖິງຂໍ້ຕົງໄດ້ດ່ານບໍ່ແສລຄ່າ. ໂທທາງເປີ 1-800-952-3455 (TTY: 711) ຂໍ້ວັນ Medica, ໂທ 1-877-317-2410 (TTY: 711) ຂໍ້ວັນ Dean Health Plan/Prevea360 Health Plan ທີ່ ລົມກັບຜູ້ທີ່ບໍ່ວິການຂອງທ່ານ.

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

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

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

Karen/ထားချွန်လိုအပ်: ဟန်သူ၏ဟန်သူး - နမ်းကတိကေညီကိုယ် တုဒိသိဒ္ဓရီ ကျိုးတုန်ခိုင်တွဲမေစာ၊ လာတလော်ဘုရာ်လာဂုရာ်စုံလာနိုင်လို့၊ တုဒိသိဒ္ဓရီ ပူနှံခြေကုံးဂိုဏ်တာဆူးအောက် ပီးလိုအပ်တုန်တိစားမေစားလာအကြော်အသာ် လာကဟုံ့တုဂုံးတုန်ကျိုး၊ လာတလော်ဘုရာ်အောက်တွဲမေစာ၊ လာတလော်ဘုရာ်လာဂုရာ်စုံလာနိုင်လို့၊ ကို 1-800-952-3455 (TTY: 711) လာ Medica အောက်၊ ကို 1-877-317-2410 (TTY: 711) လာ Dean Health Plan/Prevea360 Health Plan အောက်, မူတာမူး ကတိတုန်ခိုင်တွဲတွေကို။

Amharic/ አማርኛ:- አማርኛ የሚኖሩት ካሆን፣ የአማርኛ የፌዴራል አገልግሎት በነፃ ይቀረብልዋል፡፡ መረጃና በተደረገኝ ቅድሚች ለማቅረብ ተገበረ የሆነ ተጨማሪ እንዱታ እና አገልግሎቶች እና ደረሰኑ በነፃ ይገኘል፡፡ ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጥና እቅዱ/Prevea360 የጥና እቅዱ በ1-877-317-2410 (TTY: 711) ይደውሉ ወደምሳሌ ለእድገትና አቅራቢ የሆነዎን የኩጌዎች፡፡

CONTACT INFORMATION

The specific Claims Administrator customer service phone number for your medical or pharmacy benefits plan is found on the back of your ID card.

General Customer Service:

Medical Claims Administrator

MEDICA

(866) 839-4015

TTY Users: **711**

M–F: 7 a.m. to 8 p.m. CT (excluding Thursdays 8 a.m. to 9 a.m. CT and holidays)

Saturday: 9 a.m. to 3 p.m. CT

Find more information about your medical benefits by logging on to **Medica.com/SignIn**.

Pharmacy Benefits

Alluma **(877) 239-7159**

Find more information about your pharmacy benefits by logging on to **Medica.com/SignIn** and selecting **Go to Alluma** under **Tools + Resources**.

Enrollment/Eligibility Questions:

HR Connect

200 First Street SW
Rochester, MN 55905

(507) 266-0440 or **(888) 266-0440**

Medica CallLink NurseLine:

(800) 226-1144 for 24/7 nurse line assistance

Welcome!

We're glad you're a covered person under the plan. Health coverage can be complicated. The information found in the pages of this plan can help you better understand your coverage and how it works.

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

Some terms used have specific meanings.

In this plan, the words "you," "your" and "yourself" refer to you, the covered person. See the **Definitions** section at the end of this document for more terms with specific meanings.

Medica is the claims administrator for your medical claims, including professionally administered drugs. Alluma administers your pharmacy benefits including prescriptions filled at retail pharmacies, mail service pharmacy and specialty pharmacy that are not professionally administered. You need to follow the processes and procedures outlined in this Benefits Booklet for the appropriate claims administrator, depending on whether the service or claim is medical or pharmacy. If you have questions about a claim or service, call Medica or Alluma as applicable at one of the telephone numbers listed inside the front cover or on the back of your ID card. Medica has no responsibility for any pharmacy service, claim, or network or the administration of pharmacy benefits. Alluma has no responsibility for any medical service, claim, or network or the administration of medical benefits.

Where to Find It

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

Do you need...	Read section(s):
<i>Immediate medical attention?</i> <ul style="list-style-type: none">• Ambulance• Emergency room• Urgent care	Ambulance Emergency Room Care Physician and Professional Services
<i>Quick access to care?</i> <ul style="list-style-type: none">• Convenience care• Retail health clinic• Virtual care• Telehealth	Physician and Professional Services Telehealth Services
<i>To visit a provider or clinic?</i> <ul style="list-style-type: none">• Office visit	Physician and Professional Services
<i>Preventive care?</i> <ul style="list-style-type: none">• Immunizations• Physicals• Women's preventive services	Preventive Health Care
<i>Prescription drugs or supplies?</i> <ul style="list-style-type: none">• Diabetic equipment and supplies• Outpatient medications• Preventive medications and products• Specialty medications	Pharmacy and Prescription Drugs
<i>A medical test?</i> <i>Examples: blood work, ultrasounds</i> <ul style="list-style-type: none">• Genetic testing and counseling• Lab and pathology services• X-rays, imaging, MRI, CT and PET CT scans	Genetic Testing and Counseling Lab and Pathology X-Rays and Other Imaging

Do you need...	Read section(s):
Outpatient surgery? <ul style="list-style-type: none">• Anesthesia services• Outpatient/ambulatory surgical center services (facility charge)• Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Services provided during a hospital stay? <ul style="list-style-type: none">• Anesthesia services• Hospital services (facility charge)• Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Behavioral health – mental health or substance use services? <ul style="list-style-type: none">• Inpatient services• Office visit	Behavioral Health – Mental Health and Substance Use
Pregnancy care services? <ul style="list-style-type: none">• Breast pumps• Inpatient services• Postnatal services• Prenatal services	Durable Medical Equipment, Prosthetics and Medical Supplies Pregnancy – Maternity Care
Medical supplies or equipment? <i>Examples: crutches, CPAP, wheelchair, oxygen</i> <ul style="list-style-type: none">• Insulin pumps and related supplies• Durable medical equipment and medical supplies• Hearing aids• Prosthetics	Durable Medical Equipment, Prosthetics and Medical Supplies
Medical-related dental care? <ul style="list-style-type: none">• Accident-related dental services• Oral surgery• Treatment of temporomandibular joint (TMJ) and craniomandibular disorder	Medical-Related Dental Services Temporomandibular Joint (TMJ) and Craniomandibular Disorder
Help recovering? <i>Example: Help received after a hospital stay, injury or surgery</i> <ul style="list-style-type: none">• Home health care services• Physical, speech and occupational therapies• Skilled nursing facility services	Home Health Care Rehabilitative and Habilitative Therapies Skilled Nursing Facility

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Introduction

This benefits booklet for the Mayo Medicare Supplement option under the Mayo Medical Plan (plan) provides information that is applicable to the plan benefits offered under the Mayo Clinic Health & Welfare Benefits Plan. This benefits booklet describes your plan benefits, how to submit a claim for benefits, who reviews claims for benefits and other important information about the plan.

The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (General Information Booklet) provides information about eligibility for coverage under the plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you may be able to continue coverage under the plan if it ends. It also contains information such as who has the right to amend and terminate the plan.

This benefits booklet, together with the General Information Booklet, constitutes the Summary Plan Description for the plan as of January 1, 2025 and replaces all prior descriptions of the plan. It is intended to provide a summary of your benefits available under the plan. If there are any discrepancies between the Summary Plan Description and the governing plan documents, the plan documents will control.

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

Eligibility

You are eligible for coverage under the plan only if you are an eligible employee as described in the *Who is Eligible* section of the General Information Booklet. For more information on your eligible dependents, please see the *Eligible Family Members* section of the General Information Booklet.

Medical coverage in retirement

1. Requirements

In order to continue coverage under the Mayo Medical Plan during retirement, you must have retired on or before December 31, 2014 and have met the following age and continuous service requirements except on a limited basis and duration of time as noted in the next paragraph.

If you retire on January 1, 2015 or later, are under 65 and meet the following age and continuous service requirements, you are eligible to remain on the Mayo Medical Plan. Upon Medicare eligibility, retirees will move to the private Medicare marketplace through Via Benefits and will no longer be eligible for coverage under the Mayo Medical Plan.

If you retire on January 1, 2015 or later, are 65 or over and meet the following age and continuous service requirements, you are eligible to select a plan from the private Medicare marketplace through Via Benefits and will no longer be eligible for coverage under the Mayo Medical Plan.

Coverage through the Mayo Medical Plan is available under the Mayo Premier or Mayo Select plan options. Current Mayo Custom participants will have the opportunity to enroll in Mayo Premier or Mayo Select at retirement.

Coverage under Via Benefits is only available if you had Mayo Medical Plan coverage immediately prior to reaching age 65.

Retirement Age	Required Years of Service
62 and over	10 continuous years
60 and 61	15 continuous years
55 through 59	20 continuous years
Under age 55	30 continuous years

2. **Continuous Service**

Continuous Service for purposes of retiree medical eligibility has the same definition as provided under the Mayo Pension Plan.

3. **Enrollment**

Eligible retirees will be given an open enrollment period within 31 days of retirement to enroll in the plan. Subject to the next section, retirees who decide not to enroll at the time of retirement will waive their rights and rights of eligible family members to retiree medical coverage and will not have any option or ability to participate in the Mayo Medical Plan at any time based on retiree status. In other words, you have a one-time election for retiree coverage unless the circumstances of the next section apply. In addition, if you elect or previously elected retiree medical coverage, but later eliminate, drop or lose the retiree coverage at any time and for any reason, you and your eligible family members will not have the opportunity to re-enroll to obtain coverage in this plan or any other component of the Mayo Medical Plan based on retiree status.

4. **Retirement and re-hire at Mayo Clinic site**

If you retire from a Mayo Clinic site and elect to enroll in applicable retiree coverage prior to January 1, 2015, but you later are rehired at Mayo Clinic or an affiliate on or after January 1, 2015, such rehire may impact your retiree medical election. If you are re-hired in a benefit eligible position at Mayo Clinic or an affiliate that offers coverage under the Mayo Medical Plan, you lose your retiree coverage election and may enroll in applicable coverage as an active employee. When your employment is terminated, you will be considered retired as of that date and your eligibility for retiree medical coverage will be based on the terms and conditions of the retiree medical coverage offered at that time. If you are re-hired in a non-benefit eligible position on or after January 1, 2015, you may retain your prior retiree coverage election as long as you remain enrolled in that plan and do not accept any offer of health plan coverage that may be required to be offered to you under the Affordable Care Act. If you do not elect retiree coverage within the required timeframe, you and your eligible family members will no longer be eligible at any time for retiree coverage under the Mayo Medical Plan.

You will be given an open enrollment period of 31 days from the date of termination or reduction in hours to enroll in retiree medical. If you do not enroll at this time, you will not be eligible for any ongoing retiree medical coverage as described above. If you do enroll as a retiree, you will be subject to all of the terms and limitations described in the plan.

5. Employer subsidized retiree medical premiums

You may be eligible for an employer subsidized retiree medical premium. Please note that not all participating employers offer a subsidized premium. In order to receive a subsidized retiree medical premium, the general requirements are that you (1) must have a continuous service hire date prior to January 1, 2002, and (2) must have been eligible for or accruing eligibility for a subsidized Mayo Medical Plan retiree option on December 31, 2001. Please note that there are additional rules with respect to individuals who transfer between Mayo Clinic affiliated sites.

Subsidy sites include Rochester, Arizona, Florida, Mayo Clinic Ambulance sites, Decorah and Lake City. All other Mayo sites/employers are “non-subsidy sites.” To be eligible for a subsidized retiree premium, the first basic requirement is that the continuous service hire date be before January 1, 2002.

Please note: Eau Claire physicians are also eligible for subsidized retiree medical and may contact their local HR Department for more information on eligibility and plan options.

Subsidy eligibility for transfers between Mayo Clinic affiliated sites

- a. Employees that did not have rights to a subsidized retiree medical premium as of December 31, 2012 will not receive such rights by transferring to a subsidy Mayo site on or after January 1, 2013.
- b. Employees that have rights to a subsidized retiree medical premium as of December 31, 2012 will not lose those rights by transferring to a non-subsidy Mayo site on or after January 1, 2013.
- c. In addition, the following rules apply:
 - i. **Transfers from a non-subsidy site to a subsidy site:**
 - a) Before January 1, 2013:
Such employee will be entitled to the subsidized retiree medical premium in place at the subsidy site at the time of retirement.
 - b) On or after January 1, 2013:
Such employee will not be entitled to a subsidized retiree medical premium.
 - ii. **Transfers from a subsidy site to a non-subsidy site:**
 - a) Before January 1, 2013:
Such employees are not entitled to a subsidized retiree medical premium.
 - b) On and after January 1, 2013:

Such employees are entitled to the subsidized retiree medical premium in place at the time of retirement at the subsidy site they transferred from.

iii. **Transfers from a subsidy site to another subsidy site:**

a) Before January 1, 2013:

Such employees are entitled to a subsidized retiree medical premium at the site at which they retired from.

b) On or after January 1, 2013:

Such employees are entitled to the subsidized retiree medical premium in place at the time of retirement at the subsidy site they transferred from.

6. Attaining Medicare eligibility

a. **If you are retired**

If you are enrolled in the plan on the first day of the month in which your 65th birthday or your eligible family member's 65th birthday falls, you are considered to have enrolled in Medicare Part B with the Social Security Administration, and the coverage will be moved to the Mayo Medicare Supplement (if retired on or before December 31, 2014) or Via Benefits (if retired on or after January 1, 2015), (regardless of the Mayo Medical Plan enrollment at that time). If you or your eligible family member's birthday is the first of the month, you are eligible for Medicare on the first day of the previous month. For example, your birthday is April 1; you are Medicare eligible on March 1.

Medicare will become the primary payer of claims for you if you are age 65 or older and retired. Medicare is also the primary payer of claims for your spouse if age 65 or older and you are retired. If eligible for the Mayo Medicare Supplement, your benefit will be reduced by the amount Medicare pays or would have paid if Medicare coverage had been in effect. In other words, even if you do not apply for Medicare when eligible, your Mayo Medicare Supplement will pay only for the portion of expense Medicare coverage would not pay.

If you marry or remarry during retirement and are enrolled in the plan, your spouse and any newly eligible family members are eligible for coverage on the date of your marriage. You must notify HR Connect within 31 days of the date of marriage to add your spouse and eligible family members to your coverage. The effective date of coverage is the date of marriage.

If you are retired (but less than age 65) and eligible for Medicare due to end-stage renal disease, after 30 months of Medicare eligibility or entitlement or Medicare eligible for any disability after two years, the plan will pay secondary to Medicare.

b. **If you are still working**

Medicare benefits are available to anyone who reaches age 65, even if not retired. However, if you are age 65 or older and you are still working, your Mayo coverage will continue and will be primary, and you may not need to purchase Medicare Part B. Instead, you can wait until you are no longer working and enroll at that time. You have 31 days from your last day of work to enroll in Medicare Part B. If you are still working, and your spouse is 65 or older and not working, your Mayo coverage will remain primary and your spouse may not need to purchase Medicare Part B. Instead, the spouse can wait until you are no longer working and enroll at that time. Contact your local Social Security Office for additional information regarding Medicare eligibility and enrollment as there may be a late enrollment penalty if you or your spouse miss a deadline.

7. Coverage for family members after your death

If you met the required years of service listed above under **Medical coverage in retirement** for retiree coverage and if your spouse and eligible family members were enrolled in the plan at the time of your death, coverage for your spouse may be continued indefinitely upon payment of any required charges. Coverage for your eligible family member may be continued as long as they meet the definition of eligible family members. Your spouse will be covered until Medicare eligible at which they will move to the private Medicare marketplace through Via Benefits. Coverage will not be available for any spouse or eligible family member not enrolled at the time of your death. A spouse and other eligible family members covered under this provision will not be eligible to participate in the annual open enrollment.

If you had not met the required years of continuous service for retiree coverage and if your spouse and eligible family members were enrolled in the plan at the time of your death, coverage for your eligible family members will continue until they no longer meet the definition of eligible family member.

Coverage for your spouse will continue until your spouse is gainfully employed, remarried, age 65 or Medicare eligible. Coverage will not be available for any spouse or eligible family member not enrolled at the time of your death. A spouse and other eligible family members covered under this provision will not be eligible to participate in annual open enrollment.

If your spouse is eligible for coverage as an employee under the plan, contact HR Connect or your local Human Resources Department for enrollment details.

Mayo Clinic reserves the right to amend or terminate retiree medical coverage and any applicable subsidized premium at any time. You do not have vested benefits in the Mayo Medical Plan.

When you can enroll

Please refer to the *When You Can Enroll* section of the General Information Booklet for information regarding your ability to enroll in the plan during your initial enrollment period, special enrollment period and/or during an open enrollment period.

How you accept coverage

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

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

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

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

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

The sponsor or its designee is responsible for notifying you of any changes to this plan (as required by applicable law).

When coverage ends

Please refer to the *When Coverage Ends* section of the General Information Booklet for termination of coverage rules applicable to the plan, including, but not limited to, your ability to continue plan coverage under COBRA.

If you need language interpretation for medical services

Language interpretation services are available to help you understand your medical benefits under this plan. To request these services, call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card.

If you need alternative formats, such as Braille or large print, call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card to request these materials.

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

If you need language interpretation for pharmacy services

Language interpretation services are available to help you understand your pharmacy benefits under this plan. To request these services, call the telephone number for Alluma listed inside the front cover or on the back of your ID card.

Medica's nondiscrimination policy

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

If you have questions, call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card.

The Mayo Medical Plan nondiscrimination policy

Please see *General Provisions* and *Non-Discrimination Notice* sections of the General Information Booklet.

Before You Access Medical Care

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

What you must do to receive medical benefits

Each time you receive health services, you must:

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

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

Provider network

In-network medical benefits are available through your plan's provider network. To see which providers are in your plan's network, check the online search tool at Medica.com/SignIn or contact Medica Member Services. Certain providers may be in other Medica networks, but not in your network.

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

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

While a particular provider may be in your provider directory at the time you enroll, it is not guaranteed that this provider will be available to provide you with health services or will remain a network provider.

If you access services from providers that are not in your network, your out-of-network medical benefits will apply. For more information about out-of-network care, see the cost-sharing tip sheet at Medica.com/SignIn.

Medical prior authorization

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

Medica does not require prior authorization for the following:

- Emergency services
- Access to obstetrical or gynecological care from a provider who specializes in obstetrics or gynecology (although some specific services may require prior authorization)
- Pregnancy/maternity care services (covered at the appropriate in-network or out-of-network benefit levels)

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

You, someone on your behalf or your attending provider may contact Medica Member Services to request prior authorization. Your network provider will contact Medica to request prior authorization for a service or supply. If a network provider fails to request prior authorization after you have consulted with them about services requiring prior authorization, you will not be penalized for this failure. For out-of-network providers, each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. The cost to you will be 100% of the charges.

You, someone on your behalf or your attending provider must contact Medica Member Services to request prior authorization for services or supplies received from a non-network provider.

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

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

- Solid organ and blood and marrow transplant services outside the continental United States - this prior authorization must be obtained before the transplant workup is initiated;
- Out-of-network inpatient medical benefits for services from non-network providers, with the exception of emergency services;
- Out-of-network mental health and substance use disorder residential treatment facility services from non-network providers;
- Medically Necessary cosmetic services, unless otherwise indicated in this plan;

- Bariatric surgery*;
- Certain drugs and biologics administered by a healthcare professional;
- Certain medical supplies and durable medical equipment medical benefits that are greater than \$10,000*;
- All positron emission tomography (PET) scans*;
- Plasma injections*;
- Adult gender reassignment surgery services*;
- Spinal cord stimulators*;
- Vein procedures*;
- Skilled nursing facility services; and
- Out-of-network non-emergency air transportation.

*This prior authorization requirement is waived for Mayo Clinic providers.

This is not a complete list of all services and supplies that may require prior authorization.

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

- Name and telephone number of the provider making the request;
- Name, telephone number, address and, if applicable, the type of specialty of the provider you are requesting to see;
- Services being requested and the date those services are to be provided (if scheduled);
- Specific information related to your condition (for example, a letter of medical necessity from your provider); and
- Other applicable covered person information (i.e., Medica identification number).

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

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

- your attending provider believes that an expedited review is warranted; or
- if it is concluded that a delay could seriously jeopardize your life, health or ability to regain maximum function; or
- you could be subject to severe pain that cannot be adequately managed without the care or treatment you are requesting.

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

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

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

To receive in-network medical benefits for services received from a non-network provider, you, someone on your behalf or your attending provider must request prior authorization from Medica by following the steps described below. If you receive services from a non-network provider without following these steps, your out-of-network medical benefits will apply. For more information, see the tip sheet at Medica.com/SignIn.

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

What you must do:

1. You, someone on your behalf or your attending provider must request prior authorization from Medica to receive medically necessary in-network medical benefits from a non-network provider. Medica does not guarantee coverage for services that are received before you receive prior authorization.
2. Include the following information in the prior authorization request:
 - a. The time period for when services must be received,
 - b. The services to be provided, and
 - c. The name of the non-network provider.
3. If Medica approves the prior authorization request, your in-network medical benefit will apply.
4. Pay any amounts that were not approved for coverage by Medica.

*A standing request is a request to receive ongoing services from a specialist. Standing requests will only be authorized for the period of time appropriate to your medical condition. If Medica denies your request, you have the right to appeal this decision as described in **How Do I Submit a Claim**.

Medica:

1. May require that you see another network provider that Medica selects before determining that a request to see a non-network provider is medically necessary.
2. Will provide coverage for health services that are:
 - a. Otherwise eligible for coverage under this plan; and
 - b. Recommended by a network physician.
3. Will review the request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within 15 calendar days of receiving the request, provided that all information reasonably necessary to make a decision has been given to Medica. However, Medica will respond within a time period not exceeding 72 hours from the time of

the initial request if: 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

Visiting non-network medical providers and why you pay more

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

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

Be aware that if you use out-of-network medical benefits, you will likely have to pay much more than if you use in-network medical benefits. The amounts billed by the non-network provider may be more than what the plan would pay, leaving a balance for you to pay in addition to any coinsurance and deductible amount you owe. This additional amount you must pay the provider will not be counted toward your out-of-pocket maximum amount. You will owe this amount whether or not you previously reached your out-of-pocket maximum.

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

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

For more information about out-of-network care, see the tip sheet at Medica.com/SignIn.

When do I need to submit a medical claim

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

Surprise Billing Protections

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

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

1. Benefits for out-of-network emergency services at emergency facilities, except for certain post-stabilization services that you have consented to;

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

Medica will send you an Explanation of Benefits when it receives a claim. This Explanation of Benefits will include contact information for Medica in the event you receive a surprise bill. 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 or contact the No Surprises Help Desk at **(800) 985-3059**.

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

Continuity of care for medical claims

Continuity of care is the process by which Medica authorizes a covered person, 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 Medica 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:

1. The contract between Medica and the treating provider terminates without cause; or
2. You are new to Medica as a result of the sponsor changing third party administrators and your current treating provider is not a network provider.

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

1. An ongoing course of treatment for a serious acute condition;
2. An ongoing course of treatment for a chronic condition;
3. Undergoing a course of institutional or inpatient care from the provider or facility;
4. Scheduled non-elective surgery, including postoperative care;
5. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;

6. A physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or
7. A disabling or chronic condition that is in an acute phase.

If approved, continuity of care will continue until the active course of treatment is complete, or 90 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.

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

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

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

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

Before You Access Pharmacy Care

Pharmacy prior authorization

Certain prescription medications require prior authorization (approval in advance) for coverage. Your pharmacy or prescriber will be notified electronically when processing an order or prescription that requires prior authorization. If prior authorization is required and approved, the drug will be covered based on the product's formulary status. Each time prior authorization is required but not obtained the prescription will not be covered. The cost to you will be 100% of the charges.

You can access the Alluma Care formulary, which identifies medications requiring prior authorization, online by accessing the formulary document at Allumaco.com/members. You may also contact Customer Service at the pharmacy benefit telephone number listed inside the front cover or on the back of your ID card.

To file a prior authorization for prescription drugs, your provider should submit a request through SureScripts or CoverMyMeds web portal or electronically through the Electronic Health Record (EHR). Visit Allumaco.com/providers for additional information.

Visiting non-network pharmacy providers

No pharmacy benefits are available through a pharmacy that is not in the Alluma pharmacy network except in the case of an emergency. You can find a network pharmacy by logging into the Medica member portal and selecting **Medications**. If you obtain a prescription drug outside the network in an emergency, you must file a manual claim for reimbursement. Examples of emergency medications may include: antibiotics, asthma medications, or medications for allergic or anaphylactic reactions.

When do I need to submit a pharmacy claim manually

You may need to file a manual claim for reimbursement after filing a prescription without your ID card. This could be due to an emergency situation or when filling a prescription as a new employee before you have received your ID card.

To receive reimbursement for a prescription filled without your ID card, submit a Prescription Reimbursement Form, which is available online at Allumaco.com/members under the Member Links. You may also submit your claim electronically by logging in to the Medica member site and selecting "Medications/Medications + pharmacies".

What's Covered and How Much Will I Pay

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

Important information about your benefits

- Before you receive certain medical services or supplies, you will need to get prior authorization from Medica. To find out when you need to do this, see **What to keep in mind** after each benefit section or call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card. Also refer to **Before You Access Medical Care** for more information about the medical prior authorization process.
- Before you receive certain pharmacy benefits you will need to get prior authorization (approval in advance) from Alluma prior to filling your prescription. If approved, the drug will be covered based on the product's formulary status. Each time prior authorization is required but not obtained the prescription will not be covered. The cost to you will be 100% of the charges.
- The plan provides coverage for mental health and substance use disorder services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable law, requires the plan that offers mental health and substance use disorder medical and pharmacy 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 medical benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical medical benefits.
- When you use out-of-network medical benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network medical providers and why you pay more** in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.
- Certain benefits in this plan have limits. These limits might include day limits, prescription quantity limits, visit limits or dollar limits. These limits are noted in this plan document and apply whether or not you have met your deductible.

Key concepts

Deductibles

Your plan may require that you pay a certain dollar amount before your plan starts to pay. This amount is called a deductible. The table below shows whether your plan has a deductible, how much it is and whether you have separate deductibles for each family member or a combined deductible for everyone. Each benefit table in this plan shows whether the deductible applies to a particular service.

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

Out-of-pocket maximum

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

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

- Charges for services that aren't covered; and
- Charges a non-network provider bills you that are more than the non-network provider reimbursement amount; and
- Charges that exceed the lifetime maximum for fertility treatment; and
- Charges you pay in addition to your deductible, copayment or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available; and
- Charges you pay for Tier 3 (non-preferred) prescription drugs.

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

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUMS

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximums		
Your cost if you visit a:		
	In-network provider:	Out-of-network provider:
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per covered person	Nothing except \$50 per covered person for certain durable medical equipment benefits. See Durable Medical Equipment, Prosthetics and Medical Supplies for more information.	\$50
Per family	Nothing	\$100
The deductible is the amount you must pay for eligible services each calendar year before the plan will begin to pay claims. If you have family members on the plan, you will each have to meet your own individual deductible before receiving benefits, unless the family deductible is met. Once the family deductible has been met, the plan will pay benefits for all covered family members.		
Out-of-pocket maximum		
For all medical benefits except for those described in Pharmacy and Prescription Medications		
Per covered person	Nothing	\$1,000
Per family	Nothing	\$2,000
For pharmacy benefits described in Pharmacy and Prescription Medications	Applies to your combined in-network and out-of-network pharmacy benefits	Applies to your combined in-network and out-of-network pharmacy benefits
Per covered person	\$1,500	\$1,500
Per family	\$3,000	\$3,000

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximums		
Your cost if you visit a:		
	In-network provider:	Out-of-network provider:
This plan has both a per covered person out-of-pocket maximum and a per family out-of-pocket maximum. The per covered person out-of-pocket maximum applies individually to each family member until the family out-of-pocket maximum is met. Coinsurance, copayments and deductibles paid by each covered family member for covered benefits for the calendar year count toward the individual's annual per covered person out-of-pocket maximum and toward the annual per family out-of-pocket maximum.		
Lifetime maximum amount the plan will pay per covered person	Unlimited, except as specifically described in Infertility Diagnosis, Fertility Treatment and Assisted Reproductive Technology.	Unlimited, except as specifically described in Infertility Diagnosis, Fertility Treatment and Assisted Reproductive Technology. There is no out-of-network pharmacy coverage.

AMBULANCE

Ambulance		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Emergency ambulance services or emergency ambulance transportation Please note: Emergency Triage, Treat and Transport (ET3) services are covered under Emergency Benefits	Nothing	Covered as an in-network medical benefit.
2. Non-emergency licensed ambulance service as described below under What's covered Please note: Out-of-network non-emergency air ambulance services require prior authorization.	Nothing	20% coinsurance after deductible

What's covered

Non-emergency licensed ambulance transportation, that's arranged through an attending physician, is eligible for coverage when:

1. Transportation is from hospital to hospital when:
 - a. Care for your condition isn't available at the hospital where you were first admitted; or
 - b. The covered person 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
 - c. If it is required by Medica; or
2. Transportation is from hospital, long term acute hospital (LTACH) or an acute inpatient rehab (AIR) to skilled nursing facility.

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

providers and why you pay more in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.

What to keep in mind

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

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

What's not covered

1. Non-emergency ambulance transportation services, except as described above.
2. Travel to a non-qualified facility or beyond nearest qualified facility (except when travel is to a Mayo Clinic facility) or between health care facilities.

ANESTHESIA

Anesthesia		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Anesthesia services received during an office visit	Nothing	20% coinsurance after deductible
2. Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
3. Anesthesia services received during an inpatient stay Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Nothing	20% coinsurance after deductible
4. Anesthesia services received during an emergency room visit	Nothing	20% coinsurance after deductible

What to keep in mind

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

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

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

BEHAVIORAL HEALTH – MENTAL HEALTH AND SUBSTANCE USE

Behavioral Health – Mental Health and Substance Use		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Office visits, including evaluations, diagnostic and treatment services Please note: Some services received during a mental health or substance use office visit may be covered under another medical benefit in this section. The most specific and appropriate medical benefit will apply for each service received during a mental health or substance use office visit.	Nothing	20% coinsurance after deductible
2. Outpatient services, including intensive outpatient programs	Nothing	20% coinsurance after deductible
3. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, Including applied behavioral analysis. Examples of such therapy include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.	Nothing	20% coinsurance after deductible

Behavioral Health – Mental Health and Substance Use			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
4. Partial hospitalization/day treatment/high intensity outpatient program	Nothing	20% coinsurance after deductible	
5. Medication-assisted treatment Please note: When the prescription drug component of this treatment is received at a pharmacy, your pharmacy benefit will be applied.	Nothing	20% coinsurance after deductible	
6. Inpatient services (including mental health residential treatment services and substance use disorder residential treatment services) Please note: Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition. Prior authorization is required for all out-of-network inpatient admissions. See below for more information.			
a. Room and board	Nothing	20% coinsurance after deductible	
b. Hospital- or facility-based professional services	Nothing	20% coinsurance after deductible	
c. Attending psychiatrist and physician services	Nothing	20% coinsurance after deductible	

What's covered

Outpatient services include:

1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and procedures.
3. Nutritional counseling.
4. Nutritional classes billed under HCPCS code S9452.
5. Medication-assisted treatment (the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse and reduce craving in order to sustain recovery). **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your pharmacy benefit will be applied.
6. Intensive outpatient programs:
 - a. For mental health services, the program may be freestanding or hospital-based and includes a prearranged weekly schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management) that are provided over several sessions during the course of a week.
 - b. For substance use-related and addictive disorders services, the program provides structured programming for adults and adolescents, consisting primarily of counseling and education about addiction-related and mental health problems.
7. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, including applied behavioral analysis.
8. Partial hospitalization/day treatment/high intensity outpatient program. This may be in a freestanding facility or hospital based. Active treatment Active treatment includes a prearranged weekly schedule of core services provided through specialized programming with medical/psychological intervention and supervision during program hours (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management). The level of care is typically short-term intensive treatment that aims to reduce symptom disruption to the extent that intensive treatment is no longer required.
9. Individual, family and group therapy, if there is a clinical diagnosis.
10. Treatment of serious or persistent disorders.
11. Treatment of pathological gambling.

Inpatient services include:

1. Room and board.
2. Attending psychiatric and physician services.
3. Hospital- or facility-based professional services.

4. Mental health residential treatment services. These services include either:
 - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
 - A licensed or certified mental health treatment program providing intensive therapeutic services.
5. Substance use disorder residential treatment services are services from a licensed substance use disorder rehabilitation program that provides intensive therapeutic services following detoxification.

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

What to keep in mind

To be covered, services must diagnose or treat mental health conditions or substance use conditions listed in the current edition of the *International Classification of Diseases (ICD)* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

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

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

Mental health and substance use services from a non-network provider listed below will be eligible for coverage under out-of-network medical benefits. These services must be obtained from a health care professional or facility that is licensed, certified or otherwise qualified under state law to provide the mental health and substance use services and practice independently:

- Psychiatrist
- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Mental health clinic
- Mental health residential treatment center
- Substance use disorder clinic
- Substance use disorder residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides mental health and/or substance use services
- Licensed professional clinical counselor

What's not covered

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services, care or treatment that is not medically necessary.
3. Individual, family and group therapy, in the absence of a clinical diagnosis.
4. Services that are paid under state or federal law for purely educational purposes.
5. Services primarily educational in nature, except as specifically set forth in this section or other sections of this plan.
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. This includes, but is not limited to, services provided by providers who are not authorized under state law to practice independently, and services received at a halfway house, housing with support, therapeutic group home, wilderness therapy, boarding school or ranch.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
8. 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. Anonymous support groups.
12. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.

CERTAIN CANCER-RELATED TESTING

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

What's covered

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

What to keep in mind

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

CLINICAL TRIALS

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

What's covered

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

What to keep in mind

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

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

What's not covered

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

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS AND MEDICAL SUPPLIES

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Durable medical equipment and certain supplies Please note: The plan covers basic post-cataract surgery lenses and frames.	20% coinsurance after \$50 deductible	20% coinsurance after deductible
2. Orthotic and prosthetic devices, supplies and services, including their repair and replacement	Nothing	20% coinsurance after deductible
3. Scalp hair prosthesis for hair loss due to a health condition including alopecia areata or treatment for cancer, including all equipment and accessories necessary for regular use, when prescribed by a provider, unless there is a clinical basis for limitation. Coverage is limited to \$1,000 per calendar year. If the cost for scalp hair prosthesis is less than \$1,000, coverage will also be provided for any equipment or accessories necessary for regular use, when prescribed by a provider, up to a total combined dollar limit of \$1,000 per calendar year.	Nothing	20% coinsurance after deductible

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
4. Hearing aids: a. Standard hearing aids and their related fittings Coverage for standard hearing aids is limited to \$5,000 every three years. b. Bone-anchored hearing aids, cochlear implants and their related fittings (the \$5,000 limit every three years does not apply)	Nothing	20% coinsurance after deductible
5. Breast pumps (hospital grade) Please note: For non-hospital grade breast pump coverage, see Preventive Health Services .	20% coinsurance after \$50 deductible	20% coinsurance after deductible
6. Medical supplies: a. Injectable pharmaceutical treatments for hemophilia and bleeding disorders b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas when medically	20% coinsurance after \$50 deductible	20% coinsurance after deductible

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
<p>necessary.</p> <p>Conditions for which it is medically necessary include, but are not limited to:</p> <ul style="list-style-type: none"> i. Cystic fibrosis; ii. Amino acid, organic acid and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; vii. Eosinophilic colitis; and viii. Mast cell activation syndrome 		
7. Eligible ostomy supplies	20% coinsurance after \$50 deductible	20% coinsurance after deductible

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
8. Insulin pumps and their related supplies Please note: Omnipod pumps and Dexcom/ FreeStyle Libre continuous glucose monitors (CGMs) are covered exclusively under the Pharmacy benefit.	20% coinsurance after \$50 deductible	20% coinsurance after deductible
9. CPAP Machines and related supplies	20% coinsurance after \$50 deductible	20% coinsurance after deductible
10. Mandibular advancement devices for the treatment of sleep apnea Please note: This benefit does not cover devices to treat snoring	20% coinsurance after deductible	20% coinsurance after deductible

What's covered

Medica covers only a limited selection of durable medical equipment, orthotics, prosthetics and medical supplies. Medica covers orthotic and prosthetic devices or device systems, supplies, accessories, and services that are customized to the covered person's needs. Needs of the covered person 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 covered person; (2) of an irreparable change in the condition of the device or in a part of a device, or (3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Hearing aids and certain durable medical equipment, orthotics, prosthetics and medical supplies must meet specific criteria and some items ordered by your physician, even if they're medically necessary, may not be covered. Medica determines if durable medical equipment will be purchased or rented.

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

providers and why you pay more in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.

What to keep in mind

*This prior authorization requirement is waived for Mayo Clinic providers.

Medica periodically reviews and modifies the list of eligible durable medical equipment and certain supplies. To request the most up-to-date list, call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card. Medica requires prior authorization (approval in advance) before you receive certain durable medical equipment, prosthetics and/or medical supplies.*

To determine if Medica requires prior authorization for a particular piece of equipment, orthotic, prosthetic or supply, please contact Medica Member Services at one of the numbers listed at the front of this plan, by signing in at **Medica.com/SignIn** or at the number or address listed on the back of your ID card. Please see **Medical prior authorization in Before You Access Medical Care** for more information about prior authorization requirements and processes.

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

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

Formulary test strips, lancets, glucometers, syringes and diabetic needles are available exclusively through your pharmacy benefit. Insulin pumps, most CGMs and related supplies should be obtained through a durable medical equipment (DME) vendor. **Note:** Dexcom and FreeStyle Libre continuous glucose monitors can only be obtained through an Alluma network pharmacy.

In-network medical benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a network provider. In-network benefits apply when eligible orthotics and prosthetics are prescribed by a physician or licensed health care prescriber and received from a network provider. Hearing aids, when prescribed by a network provider, are covered as described in the table above.

To request a list of durable medical equipment providers and/or hearing aid vendors, call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card.

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

What's not covered

1. Durable medical equipment, supplies, orthotics, prosthetics, appliances and hearing aids not on the Medica eligible list, including but not limited to:

- Batteries, except for use in implantable devices and hearing aids;
 - Charges incurred for the rental or purchase of any type of air conditioner, air purifier or similar device or appliance;
 - Environmental change;
 - Exercise equipment
 - Food blenders;
 - Orthopedic mattresses;
 - Orthopedic shoes or similar device which is not custom made;
 - Pools, whirlpools and similar items, even if recommended, ordered or prescribed by a health care provider;
 - Room humidifiers and dehumidifiers;
 - Splints or braces used for non-medical purposes (i.e., support worn primarily during participation in sports or similar physical activities);
 - Mouth guards; or
 - Hearing aids that are available over-the-counter.
2. Charges in excess of the Medica standard model of durable medical equipment, orthotics, prosthetics or hearing aids.
 3. Repair, replacement or revision of properly functioning durable medical equipment, orthotics, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
 4. Duplicate durable medical equipment, orthotics, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.
 5. Other disposable supplies and appliances, except as described in this section and **Pharmacy and Prescription Medications.**

EMERGENCY ROOM CARE

Emergency Room Care		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Facility services provided in a hospital or facility-based emergency room	Nothing	Covered as an in-network medical benefit
2. Other professional services received during an emergency room visit (for example physician or DME)	Nothing	Covered as an in-network medical benefit
3. Anesthesia services received during an emergency room visit	Nothing	Covered as an in-network medical benefit
4. Lab and pathology services received during an emergency room visit	Nothing	Covered as an in-network medical benefit
5. X-rays and other imaging services received during an emergency room visit	Nothing	Covered as an in-network medical benefit

What's covered

Emergency services provided in an emergency room of a hospital, whether network or non-network will be covered as in-network medical benefits. Please see **Surprise Billing Protections** for more information if you receive any other bill from an emergency room provider.

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

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

GENDER REASSIGNMENT AND TRANSGENDER SERVICES

Primary Gender Reassignment Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Gender reassignment surgery services for covered persons with a diagnosis of gender dysphoria	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.
Secondary Gender Reassignment Services, numbers 2-4 below		
2. Hair removal, including laser, electrolysis, and topical anesthesia for covered persons with a diagnosis of gender dysphoria	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.

Primary Gender Reassignment Services			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
3. Facial reconstruction/contouring for covered persons with a diagnosis of gender dysphoria	<p>Covered at the corresponding in-network medical benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.</p>	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided.	<p>For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.</p>
4. Voice therapy for covered persons with a diagnosis of gender dysphoria	<p>Covered at the corresponding in-network medical benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.</p>	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided.	<p>For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.</p>

Primary Gender Reassignment Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
<p>5. Transportation reimbursement</p> <p>Transportation reimbursement is available for eligible expenses primarily for and essential to your receipt of medical care that is not available in your state of residence due to state law restrictions or limitations. International travel is not eligible for reimbursement under this travel benefit.</p> <p>Reimbursement is available for eligible expenses when you live more than 200 miles from where you receive the out of state medical care and will include transportation for you and a companion. This includes eligible transportation for you and the companion (traveling on the same day(s)) to and/or from the location where you receive such medical care. Eligible transportation expenses incurred by you and your companion (if applicable) under this section are subject to a maximum benefit of \$2,000 per person per year (i.e. \$2,000 per year if you travel without a companion and \$4,000 per year if you travel with a companion).</p> <p>Meals and lodging are not reimbursable under this benefit.</p>		

What's covered

Primary services:

Eligible surgical procedures and non-surgical services for gender reassignment are covered for covered persons with a diagnosis of gender dysphoria.

Prior authorization is required for surgical services.* For more information on gender reassignment services, go to: partner.medica.com/-/media/documents/provider/utilization-management-policies/iii-sur-20-um-policy.pdf or contact Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card.

*This prior authorization requirement is waived for Mayo Clinic providers.

Services eligible for coverage under other applicable benefits in this document:

1. Pre-gender assignment counseling services
2. Services of a licensed psychiatrist, or psychologist to diagnose and counsel the patient in the area of gender dysphoria
3. Psychological/psychiatric evaluation
4. Hormonal and genital gender assignment counseling services
5. All mental health services provided to the member before, during and after initiation of hormonal therapy
6. Pre-gender assignment medical evaluation

7. Hormonal gender assignment medical services. Includes all medical services directly related to the administration and monitoring of hormonal therapy
8. Genital surgical gender reassignment medical services
9. Pre-operation physical examination
10. Genital surgical gender reassignment inpatient and outpatient stays for eligible procedures
11. Includes all ambulatory follow-up care directly related to the genital surgical gender reassignment
12. Breast augmentation for male to female reassignment when all medical necessity criteria have been met
13. Mastectomy for female to male reassignment when all medical necessity criteria have been met.

Secondary services:

Professional, hospital and ambulatory surgical center services for secondary services as described above are covered. To be eligible, members **must have a diagnosis of gender dysphoria.**

Facial Reconstruction services include tracheal shave, thyroid chondroplasty, laryngochondroplasty, forehead contouring, cranioplasty, cheek implants, malar augmentation, brow lift; jaw and/or chin reshaping – mandibular contouring – genioplasty; lip shortening; scalp advancement; rhinoplasty - septoplasty, alarplasty.

What's not covered

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician and Professional Services** in this section.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Services and procedures primarily for cosmetic purposes.
4. Surgical correction of male breast enlargement primarily for cosmetic purposes.
5. Hair transplants/grafts.
6. Outpatient drugs provided or administered by a physician or other provider that do not meet the definition of "professionally administered drugs."
7. Coverage for prescription medications except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
8. Voice modification services or surgery.
9. Larynx change other than specified in this section
10. Liposuction

11. Body Contouring
12. Nipple tattooing
13. Blepharoplasty
14. Pectoral implant
15. Skin resurfacing

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Genetic testing received in an office or outpatient hospital when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices Please note: BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing	20% coinsurance after deductible
2. Genetic counseling, whether pre- or post-test and whether occurring in an office, clinic or telephonically Please note: Genetic counseling for BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing	20% coinsurance after deductible

What to keep in mind

Genetic testing is a complex and rapidly changing field.

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

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

When you use out-of-network medical benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the

provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network medical providers and why you pay more** in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.

What's not covered

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

HOME HEALTH CARE

Home Health Care		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Services including the following are limited to a combined maximum of 90 visits per calendar year:		
a. Intermittent (part-time) skilled nursing care when you are homebound, provided by or supervised by a registered nurse	Nothing	20% coinsurance after deductible
b. Services received in your home from a physician	Nothing	20% coinsurance after deductible
c. Skilled physical, speech or occupational therapy when you are homebound	Nothing	20% coinsurance after deductible
Intermittent skilled nursing care consists of visits of up to two consecutive hours of care per date of service.		
Home health care medical benefits described under #1 are limited to a combined maximum of 90 visits per calendar year. Please note: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.		
If you are also enrolled in the Medical Assistance Program, you may be eligible for additional skilled nursing care.		
2. Home infusion therapy	Nothing	20% coinsurance after deductible
3. Palliative care when not homebound	Nothing	20% coinsurance after deductible
There is a maximum of 8 visits per covered person per calendar year		

Home Health Care		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
<p>Please note: Medica will waive the requirement that you be homebound for a limited number of home visits if you have a life-threatening, non-curable condition which has a prognosis of survival of two years or less. Additional palliative care visits are eligible under the home health services medical benefit if you are homebound and meet all other requirements as defined in this section.</p>		

What's covered

Home health care is covered when ordered by a physician and received from a home health care agency that is authorized by the laws of the state in which treatment is received.

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

What to keep in mind

Medica considers you homebound when leaving your home would directly and negatively affect your physical health. A dependent child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

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

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

What's not covered

1. Extended hours home care.

2. Companion, homemaker and personal care services.
3. Services for self-treatment or by persons who are family members or who share your legal residence.
4. Custodial care and other non-skilled services.
5. Physical, speech or occupational therapy provided in your home for convenience.
6. Services provided in your home when you are not homebound.
7. Services educational in nature, except as specifically described in this plan.
8. Vocational and job rehabilitation.
9. Recreational therapy.
10. Self-care and self-help training (non-medical).
11. Health club memberships.
12. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** and **Pharmacy and Prescription Medications** in this section.
13. Voice training.
14. Home health aide services.
15. Room and board.

HOSPICE SERVICES

Hospice Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Hospice and bereavement services	Nothing	20% coinsurance after deductible

What's covered

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

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

What to keep in mind

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

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

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

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

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

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

1. Be a terminally ill patient; and

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

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

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

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

What's not covered

1. Respite care for more than five consecutive days.
2. Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.
3. Services not included in the hospice program's plan of care, including room and board charges or fees.
4. Services not provided by the hospice program.
5. Hospice daycare, except when recommended and provided by the hospice program.
6. Services for self-treatment or by persons who are family members or who share your legal residence.
7. Housekeeping or meal services in your home, except when recommended and provided by the hospice program.
8. Custodial care and other non-skilled services.

HOSPITAL SERVICES

Hospital Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Outpatient hospital or ambulatory surgical center services, including services provided in a hospital observation room	Nothing	20% coinsurance after deductible
2. Inpatient services For associated physician services, see Physician and Professional Services in this section. Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Nothing	20% coinsurance after deductible
3. Inpatient services provided through a home hospitalization program, where available, as specifically described in this Hospital Services section. For associated physician services, see the benefits described for physician services received in an inpatient setting under Physician and Professional Services in this plan.	Nothing	No coverage

What's covered

1. Hospital and ambulatory surgical center services;
2. Phase I and Phase II cardiac rehabilitation; and

3. Respiratory therapy.

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

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

Where available, certain network hospitals are designated facilities for the provision of inpatient services in a covered person's home through a home hospitalization program. Covered persons 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 Medica Member Services at one of the telephone numbers listed at the front of this plan.

What to keep in mind

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

A physician must direct your care.

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

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

What's not covered

1. Outpatient drugs received from a hospital that do not meet the definition of "professionally administered drugs" or are not received from an emergency room or a hospital observation room.
2. Coverage for prescription medications except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
3. Personal comfort or convenience items or services.

4. Cosmetic surgery/non-functional surgery and any subsequent surgery related to such surgery unless medically necessary.
5. Guest trays.
6. Phase III and Phase IV cardiac rehabilitation.

INFERTILITY DIAGNOSIS, FERTILITY TREATMENT AND ASSISTED REPRODUCTIVE TECHNOLOGY

Infertility Diagnosis, Fertility Treatment and Assisted Reproductive Technology		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Office visits, including any services provided during such visits	20% coinsurance	No coverage
2. Outpatient services received at a hospital	20% coinsurance	No coverage
3. Inpatient services	20% coinsurance	No coverage
4. Services received from a physician during an inpatient stay	20% coinsurance	No coverage

What's covered

The diagnosis of infertility and certain services for fertility treatment in connection with the voluntary planning of conceiving a child are covered. Certain assisted reproductive technology services, including in vitro fertilization, are covered, whether performed or undertaken as a fertility treatment or for any other clinical reason. Coverage includes medical benefits for professional, hospital and ambulatory surgical center services, as well as the storage of sperm, ova and embryos. Fertility treatment must be received from or under the direction of a physician. See **Pharmacy and Prescription Medications** for coverage of fertility treatment drugs.

Fertility treatment services and assisted reproductive technology services, when received from a network provider, are covered as in-network benefits.

There is no coverage for out-of-network infertility diagnosis and fertility treatment medical benefits.

What to keep in mind

Coverage for fertility treatment is limited to a maximum of \$25,000 per covered person per lifetime. Once this maximum is met, there is no coverage for fertility treatment services and claims will be denied by the plan. This lifetime maximum applies to all infertility, fertility and assisted reproductive technology services, regardless of diagnosis. The lifetime maximum benefit does not apply to outpatient fertility treatment medications.

Prior authorization (approval in advance) is required before you receive certain biologics and professionally administered drugs. To determine if Medica requires prior authorization for a

particular service or treatment, please call Medica Member Services at one of the numbers listed at the front of this plan. Please see **Medical prior authorization** in **Before You Access Medical Care** for more information about prior authorization requirements and processes.

What's not covered

1. Outpatient drugs provided or administered by a physician or other provider that do not meet the definition of "professionally administered drugs."
2. Coverage for prescription medications except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
5. Services for or related to donation and storage of sperm, ova and embryos for a person not covered as a covered person under the plan.
6. Services for or related to donation, preservation and/or storage of stem cells and any other human tissue.
7. Donor sperm.
8. Donor eggs.
9. Services related to adoption.

LAB AND PATHOLOGY

Lab and Pathology		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Lab and pathology services received during an office visit	Nothing	20% coinsurance after deductible
2. Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
3. Lab and pathology services received in an inpatient setting Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Nothing	20% coinsurance after deductible
4. Lab and pathology services received during an emergency room visit	Nothing	20% coinsurance after deductible

What's covered

Lab and pathology services ordered or prescribed by a physician will be covered as in-network medical benefits if they are:

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

What to keep in mind

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

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

MEDICAL-RELATED DENTAL SERVICES

Medical-Related Dental Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Charges for medically necessary dental medical facilities and general anesthesia services that are: a. Recommended by a physician; b. Received during a dental procedure; and c. Provided to a covered person who: i. is a child under age five; or ii. is severely disabled; or iii. has a condition that requires hospitalization or general anesthesia for dental care treatment	Nothing	20% coinsurance after deductible
2. For a dependent child, orthodontia, dental implants and oral surgery for accidental dental and treatment related to cleft lip and palate	Nothing	20% coinsurance after deductible
3. Accident-related dental services (including anesthesia) to treat an injury to and to repair (not	Nothing	20% coinsurance after deductible

Medical-Related Dental Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
<p>replace) sound, natural teeth. The following conditions apply:</p> <ul style="list-style-type: none"> a. Coverage is limited to services received within 24 months from the later of: <ul style="list-style-type: none"> i. The date you are first covered under the plan; or ii. The date of the injury b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. <p>In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.</p>		
<p>4. Oral surgery for:</p> <ul style="list-style-type: none"> a. Partially or completely unerupted impacted teeth; b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or 	<p>Nothing</p>	<p>20% coinsurance after deductible</p>

Medical-Related Dental Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth		
5. Oral diagnosis dental services include:	Nothing	20% after deductible
a. Dental diagnosis and treatment in conjunction with a medical illness including x-rays, consultation, and treatment (i.e., oral cancer or jaw surgery)		
b. Routine dental exams, treatment (including tooth extractions) and x-rays		
6. Periodontics dental services include:	Nothing	No coverage
a. Periodontal		
i. Scaling and root planning		
ii. Prophylaxis		
b. Periodontal surgery		
7. Prosthodontics dental services include:	30% coinsurance	No coverage
a. Abutments and dentures		
b. Osseo prosthesis (implant)		

Medical-Related Dental Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
8. Restorative dental services include: a. Dental services including single crowns, amalgams and composites b. Titanium screw or fixture implants c. Surgical root canal	30% coinsurance	No coverage

What's covered

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

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

What to keep in mind

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

What's not covered

1. Any orthodontia, except as described in this section for accidental dental and the treatment of cleft lip and palate.
2. Endodontic procedures and treatment, unless provided as accident-related dental services as described in this section.
3. Additional dental-related items and services, including but not limited to:
 - Pontics;
 - Replacement retainers; or
 - Veneers.

PHARMACY AND PRESCRIPTION MEDICATIONS

Your cost if you visit a:			
	Mayo Clinic Pharmacy	Network Pharmacy	
Pharmacy benefits	Mayo Clinic Pharmacy Mail Service* (up to a 100-day supply)	Mayo Clinic Outpatient Pharmacy* (up to a 100-day supply except when indicated)	Alluma Pharmacy* (up to a 34-day supply)
1. Formulary generic medication (Tier 1)	\$10 maximum	\$10 maximum per each 34-day supply	\$10 maximum
2. Formulary brand or injectable medication (Tier 2)**	25% coinsurance with a \$10 minimum	30% coinsurance with a \$10 minimum	40% coinsurance with a \$15 minimum
3. Non-preferred medication (Tier 3)***	50% coinsurance with a \$10 minimum	50% coinsurance with a \$10 minimum	60% coinsurance with a \$15 minimum

*Certain specialty prescriptions are covered under the plan only when filled by the Mayo Clinic Specialty Pharmacy or a Mayo Clinic or Mayo Clinic Health System outpatient pharmacy.

**Certain GLP-1 medications used to treat diabetes or weight loss are subject to 25% coinsurance at a Mayo Clinic Outpatient or Mail Service Pharmacy.

***Non-preferred (Tier 3) prescriptions do not apply to the plan's out-of-pocket maximum.

Prior authorization

Some prescription medications require prior authorization (approval in advance) for coverage. Common examples include:

- Cancer medications
- Certain medications for diabetes
- Cystic fibrosis medications
- Growth hormones
- Medications to treat rare diseases
- Most intravenous (I.V.) drugs
- Multiple sclerosis agents
- Self-injected biologic medications

- Specialty medications
- Supply in excess of the allowed quantity limit.

The list of prescription medications that require prior authorization, the list of prescription medications with dispensing limitations, and the Alluma Care formulary are continually updated as new medications are approved and medical practice changes.

You can access the Alluma Care formulary at Allumaco.com/members. The Alluma Care formulary identifies the formulary tier and medications that require prior authorization or have quantity limits. If you have questions about your pharmacy benefits, you may contact Alluma Customer Service at the pharmacy benefit telephone number listed inside the front cover or on the back of your ID card.

If prior authorization is required and approved, the medication will be covered based on the product's formulary status. Each time prior authorization is required but not obtained the prescription will not be covered. The cost to you will be 100% of the charges.

Quantity limits

A number of prescription medications have quantity limits over a defined period of time, such as 90 days, 30 days, yearly or per fill. Prescription quantities that are issued over the specified dispensing limits are not covered, and the costs do not apply toward out-of-pocket maximum. See the Alluma Care Formulary document at Allumaco.com/members to identify medications which have quantity limits (QL) in place.

Generic medications

When a brand name medication is prescribed and a generic equivalent is available, pharmacies are required to fill your prescription with the generic medication. The determination of a medication classification as a brand name versus generic is made by external organization called First Data Bank or Medispan. If you or your prescriber requests that the pharmacy fill your prescription with the brand name medicine, you pay the difference in cost between the generic and brand name plus the applicable generic copayment or coinsurance. Your coinsurance is calculated based on the total cost of your prescription and does not include rebates or discounts that may be available to the pharmacy or the health plan. Generic medications usually fall into Tier 1 of your pharmacy benefit.

You should ask your provider to prescribe a generic drug if one is available and acceptable for you to use. You also should discuss medication alternatives with your provider and your pharmacist (before he or she issues your prescription). Generic medications offer a safe and effective alternative to higher cost brand name products.

If your health care provider writes "DAW" (dispense as written) on your prescription, you should discuss the reasons with the provider. Generally, when DAW is written on a prescription for a brand name drug that has an FDA A-rated generic equivalent, it will cost you considerably more to fill the prescription.

Weight loss medication coverage

In 2026, a lifetime benefit maximum for medications used for weight management will not apply. All members seeking coverage for GLP-1 weight management medications will be required to participate in the Practice-led Mayo Clinic Weight Management Program. To enroll in the Weight

Management Program, visit the website at mayoclinic.org/cared/guidance/weight-management-program to learn more.

Biosimilar medications

Biosimilars are safe and effective treatment options for many illnesses and are typically available at a lower cost. Biosimilars have no clinically meaningful differences from the reference biologic product. This means you can expect the same safety and effectiveness from the biosimilar over the course of treatment as you would the reference product. Your healthcare provider or the Alluma Care formulary may prefer a biosimilar medication for certain medical conditions.

Professionally administered medications

Medications that are professionally administered by a healthcare provider in an office, infusion therapy center, outpatient hospital or through home health care may require prior authorization or may not be covered. You may call Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card or visit Medica.com/ProfessionallyAdministeredDrugs.

The **What if I Have More Than One Insurance Plan** section does not apply to prescription medications.

What's covered

Prescription medications, services and supplies including but not limited to:

- Diabetic supplies (needles, syringes, glucose test strips, lancets and certain devices e.g. Omnipod, Twiist, Dexcom and Freestyle Libre);
- Fertility treatment medications are covered at 50%-60% coinsurance, considered non-preferred (Tier 3) and do not accumulate toward your out-of-pocket maximum;
- Injectable insulin (prescription only);
- Medications included on the Alluma Care formulary;
- Medications requiring a prescription, when filled at a participating Alluma network pharmacy;
- Multi-ingredient compounded medications of which at least one ingredient is a prescription legend medication;
- Prescription contraceptives; and
- Specialty medications.

What to keep in mind

The Mayo Medical Plan bases pharmacy benefits on prescription medications listed in the Alluma Care formulary. This formulary is an approved list of medications recommended for use throughout Mayo Clinic. The amount you pay will depend on the formulary tier status of the medication and the pharmacy you use to fill your prescription.

You may need to file a claim for reimbursement after filing a prescription without your member identification card. After filling a prescription in an emergency situation, submit a Prescription Reimbursement Request Form, which is available online at Allumaco.com/members under the Resource Center. Complete the form, attach copies of the prescription receipt(s) and submit the claim form to the address or fax number listed on the form. You may also submit your claim

electronically by logging in to the Medica member site and selecting **Go to Alluma**. The reimbursement you receive may be reduced to the amount the plan would have paid for a claim processed electronically.

Extended supplies of medications may be available under extenuating circumstances. Requests for any such exception to standard health plan guidelines must be approved by Alluma prior to any charges being incurred by the covered person. Any charges resulting from an exception request that does not receive such prior authorization (approval in advance) shall be deemed the sole responsibility of the covered person.

What's not covered

1. Any medications or medicines that can be purchased over-the counter (even if you have a prescription) except for insulin, diabetic supplies and those products mandated by the Affordable Care Act (ACA) or allowed by the Alluma Care formulary.
2. Any eligible prescription filled at a non-participating pharmacy, except in the case of an emergency.
3. Any prescription refilled in excess of the number of times specified by the physician's prescription or any refills dispensed more than one year from the physician's original order.
4. Blood or blood plasma.
5. Charges for the administration or injection of any medication, except for vaccine administration at certain network pharmacies.
6. Cosmetic medications including but not limited to, anti-wrinkle agents such as Renova®, hair loss agents such as Minoxidil or Rogaine® and Vaniqua® for excessive hair growth.
7. Medications that may be properly received without charge under local, state or federal programs including worker's compensation.
8. Duplicate prescription medications.
9. Over-the-counter infant formula, unless specifically addressed in the Alluma Care formulary.
10. Over-the-counter vitamins except as mandated by the Affordable Care Act (ACA).
11. Prescribed medication that is a formulary exclusion.
12. Prescription medications dispensed by a health care provider in the provider office or clinic facility for use outside the office or clinic facility unless the health care provider is part of the Alluma pharmacy network.
13. Prescription medications labeled "investigational" or "experimental", except for routine supportive medication costs considered standard of care and included in the IRB-approved clinical trial protocol. Routine medication costs include all items and services consistent with the coverage provided by the pharmacy benefit that are typically covered for a covered person who is not enrolled in a clinical trial. Routine medication costs do not include a) the investigational item, device or service itself; b) medications that are provided solely to satisfy data collection and analysis needs and that are not used in the direct

clinical management of the patient; and c) medications that are clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

14. Any use of a medication for an indication, dose or schedule that is investigative.
15. Prescriptions filled prior to the allowed refill date.
16. Replacement of lost, stolen or damaged prescription medications.
17. Self-prescribed controlled substances or other prescription medications for self and/or eligible family members.
18. Therapeutic devices or appliances, supportive garments and other non-medicinal substances (regardless of intended use, except for diabetic supplies, Omnipod, Twiist and certain continuous glucose monitors).
19. Topical dental preparation fluoride supplements except as mandated by the Affordable Care Act (ACA).

PYHSICIAN AND PROFESSIONAL SERVICES

Physician and Professional Services		
	Your cost if you visit a:	
Medical benefits	In-network provider:	Out-of-network provider:
1. Office visits Please note: Some services received during an office visit may be covered under another medical benefit in this section. The most specific and appropriate medical benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and in X-Rays and Other Imaging for coverage of these services. In such instances, both an office visit coinsurance and an outpatient surgical or imaging coinsurance apply.	Nothing	20% coinsurance after deductible

Physician and Professional Services			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
2. Urgent care center visits Please note: Some services received during an urgent care center visit may be covered under another medical benefit in this section. The most specific and appropriate medical benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and in X-Rays and Other Imaging for coverage of these services. In such instances, both an urgent care center visit coinsurance and outpatient surgical coinsurance apply.	Nothing	20% coinsurance after deductible	
3. Convenience care <ul style="list-style-type: none"> a. Retail health clinic b. Virtual care 	Nothing Nothing	20% coinsurance after deductible 20% coinsurance after deductible	
4. Surgical services (as defined in the Physicians' Current Procedural Terminology code book): <ul style="list-style-type: none"> a. Received from a physician during an office visit 	Nothing	20% coinsurance after deductible	

Physician and Professional Services			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
b. Received from a physician during an urgent care visit	Nothing	20% coinsurance after deductible	
c. Received from a physician during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible	
d. Received from a physician in an inpatient setting	Nothing	20% coinsurance after deductible	
<p>Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.</p>			
5. Non-surgical services received from a physician in an inpatient setting	Nothing	20% coinsurance after deductible	
<p>Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.</p>			
6. Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	Nothing	20% coinsurance after deductible	
7. Allergy shots	Nothing	20% coinsurance after deductible	

Physician and Professional Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
8. Diabetes self-management training and education, including medical nutrition therapy received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	Nothing	20% coinsurance after deductible
9. Acupuncture Limited to 20 visits per calendar year.	Nothing	No coverage
10. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing	20% coinsurance after deductible

What's covered

In-network benefits apply to:

1. Professional services received from a network provider;
2. Emergency services received from network or non-network providers; or
3. Certain out-of-network professional and physician services when the circumstances described in **Surprise Billing Protections** apply.

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

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain services. To determine if Medica requires prior authorization for a particular service or treatment, please call

Medica Member Services at one of the numbers listed at the front of this plan. Please see **Medical prior authorization** in **Before You Access Medical Care** for more information about prior authorization requirements and processes.

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

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

What's not covered

1. Outpatient drugs provided or administered by a physician or other provider that do not meet the definition of "professionally administered drugs."
2. Coverage for prescription medications except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
3. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
4. Chiropractic services, including but not limited to x-rays, office visits and evaluations.
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.

PREGNANCY – MATERNITY CARE

Pregnancy – Maternity Care		
	Your cost if you visit a:	
Medical benefits	In-network provider:	Out-of-network provider:
1. Prenatal care services that are considered preventive health services	Nothing	Not covered
2. Prenatal care services that are not considered preventive health services	<p>Covered at the corresponding in-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.</p>
3. Inpatient stay for labor and delivery services – for the mother	Nothing	20% coinsurance after deductible
Please note: Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay. Prior authorization is required for all out-of-network inpatient admissions. See below for more information.		

Pregnancy – Maternity Care		
	Your cost if you visit a:	
Medical benefits	In-network provider:	Out-of-network provider:
4. Physician services received during an inpatient stay for labor and delivery – for the mother Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.*	Nothing	20% coinsurance after deductible
5. Inpatient stay – for your newborn Please note: Your newborn must be added as a dependent on your plan for this coverage to apply. Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Nothing	20% coinsurance after deductible
6. Physician services received during an inpatient stay – for your newborn Please note: Your newborn must be added as a dependent on your plan for this coverage to apply. Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Nothing	20% coinsurance after deductible

Pregnancy – Maternity Care		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
7. Labor and delivery services at a free-standing birth center		
a. Facility services for labor and delivery – for the mother	Nothing	20% coinsurance after deductible
<p>Please note: Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.</p>		
b. Physician services received for labor and delivery – for the mother	Nothing	20% coinsurance after deductible
c. Facility services for labor and delivery – for your newborn	Nothing	20% coinsurance after deductible
<p>Please note: Your newborn must be added as a dependent on your plan for this coverage to apply.</p>		
d. Physician services – for your newborn	Nothing	20% coinsurance after deductible
<p>Please note: Your newborn must be added as a dependent on your plan for this coverage to apply.</p>		
8. Postnatal services	Nothing	20% coinsurance after deductible
9. Home health care visit following delivery	Nothing	20% coinsurance after deductible

Pregnancy – Maternity Care		
Medical benefits	Your cost if you visit a:	
	In-network provider:	Out-of-network provider:
10. Pregnancy termination services	<p>Covered at the corresponding medical or pharmacy benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level. Prescription medications are covered in accordance with the Pharmacy and Prescription Medications section of this benefits booklet.</p>	<p>Covered at the corresponding medical or pharmacy benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level. Prescription medications are covered in accordance with the Pharmacy and Prescription Medications section of this benefits booklet.</p>
11. Transportation reimbursement		
<p>Transportation reimbursement is available for eligible expenses primarily for and essential to your receipt of medical care that is not available in your state of residence due to state law restrictions or limitations. International travel is not eligible for reimbursement under this travel benefit.</p> <p>Reimbursement is available for eligible expenses when you live more than 200 miles from where you receive the out of state medical care and will include transportation for you and a companion. This includes eligible transportation for you and the companion (traveling on the same day(s)) to and/or from the location where you receive such medical care. Eligible transportation expenses incurred by you and your companion (if applicable) under this section are subject to a maximum benefit of \$2,000 per person per year (i.e. \$2,000 per year if you travel without a companion and \$4,000 per year if you travel with a companion).</p> <p>Meals and lodging are not reimbursable under this benefit.</p>		

What's covered

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

Preventive prenatal benefits allow one ultrasound in the first trimester and one in the second trimester with no member cost-sharing. All other ultrasounds will be covered with regular imaging benefits.

In-network benefits apply to emergency services received from a network or non-network provider. If you are admitted to a non-network hospital from an emergency department of a hospital, you will be eligible for in-network benefits until you have validly consented to post-stabilization care from non-network providers. Please see **Surprise Billing Protections** for more information.

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

Prior authorization (approval in advance) is required before you receive out-of-network inpatient admission services. Please see **Medical prior authorization** in **Before You Access Medical Care** for more information about prior authorization requirements and processes.

*This prior authorization requirement is waived for Mayo Clinic providers.

What to keep in mind

Enrolling your baby

Medica does not automatically know of a birth or whether you would like coverage for your baby. To enroll your newborn as a dependent, you must do so within 31 calendar days from the date of birth – see **further information in the General Information Booklet**.

Prenatal care

Covered prenatal services include:

- Office visits for prenatal care, including professional services, lab, pathology, x-rays and imaging;
- Hospital and ambulatory surgery center services for prenatal care, including professional services received during an inpatient stay for prenatal care;
- Intermittent skilled nursing care or home infusion therapy due to a high-risk pregnancy; and
- Supplies for gestational diabetes.

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

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

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

Examples of preventive prenatal care include:

- Routine prenatal obstetrical office visits
- Ultrasound; one first trimester ultrasound; one second trimester ultrasound
- Anemia screening on a routine basis
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Hepatitis B screening for pregnant women at their first prenatal visit
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening
- These services with an in-network provider will be covered with no member cost-share (there is no coverage change to these services).

Examples of non-preventive prenatal care include:

- Home care, home infusion therapy or inpatient hospital care for a high-risk pregnancy
- Less common tests for high-risk or complicated pregnancies such as amniocentesis, chorionic villi sampling, fetal stress tests
- Supplies for gestational diabetes

Labor and delivery

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

Postnatal care

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

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

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

What's not covered

1. Health care professional services, including certified nurse midwife, for labor and delivery services at home or an unlicensed, unaccredited facility.
2. Services from a doula.
3. Childbirth and other educational classes.

PREVENTIVE HEALTH CARE

Preventive Health Care		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Preventive health services, including but not limited to:		
a. Child health supervision services, including well-baby care, pediatric preventive services, appropriate immunizations, developmental assessments and appropriate laboratory services	Nothing	20% coinsurance after deductible
b. Immunizations	Nothing	20% coinsurance after deductible
c. Early disease detection services including physicals	Nothing	20% coinsurance after deductible
For item c. coverage is limited to one preventive physical exam per calendar year, unless additional visits are necessary to obtain all covered preventive health care.		

Preventive Health Care			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
d. Routine screening procedures for cancer including, but not limited to, screening for prostate cancer and colorectal cancer. See Certain Cancer-Related Testing for more information about surveillance testing for ovarian cancer for at-risk women and screening for prostate cancer for men.	Nothing	20% coinsurance after deductible	
Women's preventive health services including mammograms, screenings for cervical cancer (including pap smears), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate) and sterilization	Nothing	20% coinsurance after deductible	
e. Tobacco use counseling and intervention	Nothing	No coverage	

Preventive Health Care			
Your cost if you visit a:			
Medical benefits	In-network provider:	Out-of-network provider:	
f. Other preventive health services	Nothing	20% coinsurance after deductible	
g. Routine eye exam	Nothing	No coverage	
h. Refractive eye exams	Nothing	No coverage	

What to keep in mind

Routine preventive services are as defined by state and federal law.

If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance or deductible, as described elsewhere in this section. The most specific and appropriate medical benefit will apply for each service you receive during a visit.

For example, laboratory and diagnostic imaging may be subject to other plan benefits if determined not to be part of a preventive visit. See **X-Rays and Other 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.

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

The Mayo Medical Plan, which is subject to the Affordable Care Act's preventive services coverage mandate, must provide coverage for all of the following preventive services without imposing any copayments, coinsurance, deductibles, or other cost-sharing requirements, when delivered by in-network providers:

1. Evidence-based items or services that have in effect 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 with respect to the covered person 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 covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. With respect to covered persons who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the HRSA (including Food and Drug Administration approved contraceptive methods and sterilization procedures other than prescription drugs and related patient education and counseling).

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

Contact Medica Member Services for information regarding specific preventive health services or visit the Health & Human Services website at HHS.gov/healthcare and search for “preventive services” to learn more about what’s covered. The plan does not limit sex-specific recommended preventive services based on an individual’s sex assigned at birth, gender identity or recorded gender. Where an attending provider determines that a recommended preventive service is medically appropriate for the individual and the individual otherwise satisfies the criteria in the guidelines, the plan will provide coverage for the recommended preventive service without cost sharing.

The plan does not limit sex-specific recommended preventive services based on an individual’s sex assigned at birth, gender identity or recorded gender. Where an attending provider determines that a recommended preventive service is medically appropriate for the individual and the individual otherwise satisfies the criteria in the guidelines, the plan will provide coverage for the recommended preventive service without cost sharing.

RECONSTRUCTIVE AND RESTORATIVE SURGERY (INCLUDING MASTECTOMY RECONSTRUCTION)

Reconstructive and Restorative Surgery (Including Mastectomy Reconstruction)		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Reconstructive and restorative surgery Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.

What's covered

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

Eligible surgical procedures and non-surgical services for gender reassignment are covered. Prior authorization is required for surgical services.* For more information on gender reassignment services, go to: partner.medica.com/-/media/documents/provider/utilization-management-policies/iii-sur-20-um-policy.pdf or contact Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card.

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

Please see **Visiting non-network medical providers and why you pay more** in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.

What to keep in mind

*This prior authorization requirement is waived for Mayo Clinic providers.

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

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

What's not covered

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician and Professional Services** in this section.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Services and procedures primarily for cosmetic purposes.
4. Surgical correction of male breast enlargement primarily for cosmetic purposes.
5. Hair transplants.
6. Outpatient drugs provided or administered by a physician or other provider that do not meet the definition of "professionally administered drugs."
7. Coverage for prescription drugs except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
8. Cosmetic surgery/non-functional surgery and any subsequent surgery related to such surgery unless medically necessary.

REHABILITATIVE AND HABILITATIVE THERAPIES

Rehabilitative and Habilitative Therapies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Physical therapy services received outside of your home		
a. Habilitative services	Nothing	20% coinsurance after deductible Coverage for physical therapy is limited to a maximum of 20 visits per calendar year. Please note: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.
b. Rehabilitative services	Nothing	20% coinsurance after deductible Coverage for physical therapy is limited to a maximum of 20 visits per calendar year. Please note: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing	20% coinsurance after deductible
b. Rehabilitative services	Nothing	20% coinsurance after deductible
3. Occupational therapy services received outside of your home		

Rehabilitative and Habilitative Therapies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
a. Habilitative services	Nothing	20% coinsurance after deductible
b. Rehabilitative services	Nothing	20% coinsurance after deductible

What's covered

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

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

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

What to keep in mind

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

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

What's not covered

1. Services educational in nature, except as specifically described in this plan.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).
5. Health club memberships.
6. Voice training.
7. Group speech therapy.
8. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
9. Custodial care and other non-skilled services.

10. Residential charges billed by a skilled nursing facility, unless part of the 30-day skilled nursing care facility stay (subacute).

SKILLED NURSING FACILITY

Skilled Nursing Facility		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Daily skilled care or daily skilled rehabilitation services, including room and board	Nothing	20% coinsurance after deductible
2. Skilled physical, speech or occupational therapy when room and board is not eligible to be covered	Nothing	20% coinsurance after deductible
3. Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing	20% coinsurance after deductible
Medical benefits are limited to 30 days per covered person per calendar year for in-network and out-of-network services combined. Days covered by Medicare will count toward your limit of 30 days under the plan. Please note: This day limit does not apply to services for treatment of mental health and/or substance use conditions.		
Please note: Prior authorization is required for all inpatient admissions. See below for more information.		

What's covered

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

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

What to keep in mind

Prior authorization (approval in advance) is required before you receive skilled nursing facility services. Please see **Medical prior authorization** in **Before You Access Medical Care** for

more information about prior authorization requirements and processes. In this section, room and board includes coverage of health services and supplies.

What's not covered

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services educational in nature, except as specifically described in this plan.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health club memberships.
7. Voice training.
8. Group speech therapy.
9. Long-term care.
10. Charges to hold a bed during a skilled nursing facility absence due to hospitalization or any other reason.

SLEEP STUDIES

Sleep Studies		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Sleep studies conducted at home	Nothing	20% coinsurance after deductible
2. Professional services received for sleep studies conducted at home	Nothing	20% coinsurance after deductible
Please note: Sleep studies conducted at home include two separate services. You may have a cost for each service.		
3. Sleep studies conducted at a facility	Nothing	20% coinsurance after deductible
4. Professional services received for sleep studies conducted at a facility.	Nothing	20% coinsurance after deductible
Please note: Sleep studies conducted at a facility include two separate services. You may have a cost for each service.		

What to keep in mind

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

TELEHEALTH SERVICES

Telehealth Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Health services, including mental health, behavioral health and substance use disorder services delivered by means of telehealth Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level, inpatient services are covered at the inpatient services in-network medical benefit level and behavioral health services are covered at the corresponding behavioral health services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level, inpatient services are covered at the inpatient services out-of-network medical benefit level and behavioral health services are covered at the corresponding behavioral health services out-of-network medical benefit level.

What to keep in mind

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

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

Prior authorization (approval in advance) is required before you receive out-of-network inpatient admission services. Please see **Medical prior authorization** in **Before You Access Medical Care** for more information about prior authorization requirements and processes.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.

What to keep in mind

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

What to keep in mind

Prior authorization (approval in advance) is required before you receive out-of-network inpatient admission services. Please see **Medical prior authorization** in **Before You Access Medical Care** for more information about prior authorization requirements and processes.

TRANSPLANT SERVICES

Transplant Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. Solid organ and blood and marrow transplant services Prior authorization is required for all transplant services outside the continental United States; this prior authorization must be obtained before the transplant workup is initiated. Please note: Prior authorization is also required for all out-of-network inpatient admissions. See below for more information.	Covered at the corresponding in-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network medical benefit level and surgical services are covered at the surgical services in-network medical benefit level.	Covered at the corresponding out-of-network medical benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network medical benefit level and surgical services are covered at the surgical services out-of-network medical benefit level.

Transplant Services		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
<p>2. Transportation reimbursement, as described below, is available for expenses primarily for and essential to the receipt of transplant services.</p> <p>Reimbursement will be for you and a companion or companions whose presence with you is necessary and essential in order for you to receive transplant services, when you receive approved transplant services at a designated facility selected exclusively for medical reasons and you live more than 200 miles from that facility, and will include:</p> <ul style="list-style-type: none"> a. Transportation for you and one companion (traveling on the same day(s)) to and/or from a designated facility for transplant services for pre-transplant, transplant and post-transplant services. If you are a minor child, transportation expenses for two companions will be reimbursed, provided that the presence of both companions is necessary for you to receive transplant services. b. Airfare is reimbursable only if the travel distance from your home to the designated transplant facility is 200 miles or more. <p>There is a lifetime maximum of \$10,000 per covered person for all transportation expenses incurred by you and your companion(s). Once this maximum has been met, there is no additional reimbursement benefit available.</p> <p>Lodging and meals are not reimbursable under this benefit.</p> <p>You are responsible for paying all amounts not reimbursed under this benefit. Such amounts do not count toward your out-of-pocket maximum.</p>		<p>Reimbursement of expenses for out-of-network services is not covered.</p>

What's covered

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

When you use out-of-network medical benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the

provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network medical providers and why you pay more** in **Before You Access Medical Care** for more information regarding out-of-pocket costs associated with out-of-network medical benefits.

What to keep in mind

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

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

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

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

The list above is not a comprehensive list of eligible transplant services.

In-network medical benefits apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a facility that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities. Contact Medica Member Services to be connected with a Medica case manager for your transplant care.

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

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

What's not covered

1. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.

2. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes services and related expenses for weight loss programs, nutritional supplements and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Outpatient drugs provided or administered by a physician or other provider that do not meet the definition of "professionally administered drugs."
9. Coverage for prescription medications except as described in **Pharmacy and Prescription Medications** or otherwise described as a specific benefit elsewhere in this section.
10. Services or associated charges with the purchase of any organ.
11. Transportation services of a living donor.
12. Meals or lodging expenses.

X-RAYS AND OTHER IMAGING

X-Rays and Other Imaging		
Your cost if you visit a:		
Medical benefits	In-network provider:	Out-of-network provider:
1. X-rays and other imaging services received during an office visit	Nothing	20% coinsurance after deductible
2. X-rays and other imaging services received during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
<p>Please note: For these services received during an emergency room visit, see Emergency Room Care.</p>		
3. X-rays and other imaging services received in an inpatient setting	Nothing	20% coinsurance after deductible
<p>Please note: Prior authorization is required for all out-of-network inpatient admissions. See below for more information.</p>		
4. MRI, CT and PET CT scans	Nothing	20% coinsurance after deductible
<p>Please note: PET scans require prior authorization.*</p>		
5. X-rays and other imaging services received during an emergency room visit	Nothing	20% coinsurance after deductible

What to keep in mind

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

*This prior authorization requirement is waived for Mayo Clinic providers.

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

What's Not Covered

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

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. Hearing aids that are available over-the-counter.
5. The purchase, replacement or repair of eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction and their related fittings.
6. A drug, device, medical treatment or procedure that is investigative.
7. Services or supplies not directly related to your care.
8. Autopsies.
9. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
10. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
11. Chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
12. Personal comfort or convenience items or services.
13. Custodial care, unskilled nursing or unskilled rehabilitation services.
14. Respite or rest care except as otherwise covered in **Hospice Services** in **What's Covered and How Much Will I Pay**.
15. Travel, transportation or living expenses, except as described in **Transplant Services, Gender Reassignment and Transgender Services** and **Pregnancy – Maternity Care** in **What's Covered and How Much Will I Pay**.
16. Household equipment, fixtures, home modifications and vehicle modifications.

17. Charges billed that are not in compliance with generally accepted coding, billing and reimbursement guidelines, including those of the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and the community.
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 covered persons 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 for self-treatment or by persons who are family members or who share your legal residence.
21. Services for which benefits have been paid under workers' compensation, employer liability or any similar law.
22. Services received before coverage under the plan becomes effective.
23. Services received after coverage under the plan ends.
24. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
25. Photographs, except for the conditions of dysplastic nevi and melanoma.
26. Occlusal adjustment or occlusal equilibration.
27. Any orthodontia, except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay** for the treatment of cleft lip and palate.
28. Treatment for bruxism.
29. Services prohibited by applicable law or regulation.
30. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
31. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
32. 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.
33. Non-medical self-care or self-help training.
34. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay**.
35. Services primarily educational in nature, except as specifically set forth in this plan.
36. Coverage for costs associated with translation of medical records and claims to English.
37. Treatment for superficial veins, also referred to as spider veins or telangiectasia.

38. Services not received from or under the direction of a physician, except as described in this plan.
39. Orthognathic surgery for cosmetic purposes.
40. Health care professional services, including certified nurse midwife, for labor and delivery services at home or an unlicensed, unaccredited facility.
41. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
42. Donor sperm.
43. Donor eggs.
44. Services related to adoption.
45. Any form, mixture or preparation of non-FDA approved cannabis for medical or therapeutic use and any device or supplies related to its administration.
46. Services solely for the treatment of snoring.
47. Interpreter services.
48. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
49. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
50. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
51. Drugs, supplies and biologics that have not been approved by the U.S. Food and Drug Administration (FDA).
52. Health club memberships.
53. Long-term care.
54. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.
55. Any charges for mailing, interest and delivery, such as the cost for mailing medical records.
56. Animals and any service or treatment related to animals.
57. Charges incurred if you fail to keep a scheduled visit.
58. Adult day care programs including adult social day care and adult day health care services.
59. Financial or legal counseling services.
60. Home health aide services.
61. Charges incurred while you or an eligible family member is confined in a hospital operated by the United States of America or an agency thereof, unless payment is legally required.

62. Hippotherapy/equine assisted therapy.
63. Medical services provided via email, audio phone, tablets, portable electronic devices or common unregulated non-secure video chat applications, unless such services are provided in accordance with Medica's telehealth policies and procedures.
64. Orthokeratology.
65. Payment for medical expenses that a covered person is entitled to under Medicare, if Medicare is the primary payer under applicable federal law.
66. Sublingual immunotherapy.
67. Chiropractic services, including but not limited to x-rays, office visits and evaluations.
68. 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.
69. Services for extended hours home care.
70. Services for private duty nursing. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the member or the member's representative and not under the direction of a physician.
71. Computer software, whether downloaded, on a server or personal computer, web-based or as a mobile application ("App"), including any subscription fees related to the implementation, administration, monitoring or usage of such Apps.
72. Sales tax.

What if I Have More Than One Insurance Plan

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

Coordination for Medicare-eligible individuals

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

If you are eligible for Medicare Part B, we will consider you covered by Medicare Part B, whether or not you are actually enrolled in Medicare Part B. We will reduce your medical benefits under this plan by the amount you should have been eligible for under Medicare Part B if you had actually enrolled in Medicare Part B. You should enroll in Medicare when you are eligible to avoid large out-of-pocket expenses.

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

When coordination of medical benefits applies

1. This coordination of medical benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "this plan" are defined below.
2. If this coordination of medical benefits provision applies, **Order of medical benefit determination rules** should be looked at first. Those rules determine whether the medical benefits of this plan are determined before or after those of another plan. Under **Order of medical benefit determination rules**, the medical benefits of this plan:
 - a. Shall not be reduced when this plan determines its medical benefits before another plan; but
 - b. May be reduced when another plan determines its medical benefits first. The above reduction is described in **Effect on the medical benefits of this plan**.

Definitions that apply to this section

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

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

2. “*This plan*” is the part of the plan that provides medical benefits for health care expenses.
3. “*Primary plan/secondary plan*”. The **Order of medical 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 medical benefits are determined before those of the other plan and without considering the other plan's medical benefits.

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

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

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

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

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

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

When medical benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered

an allowable expense. Examples of such provisions are those related to second surgical opinions and preferred provider arrangements.

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

Order of medical benefit determination rules

1. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its medical benefits determined after those of the other plan, unless:
 - a. The other plan has rules coordinating its medical benefits with the rules of this plan; and
 - b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's medical benefits be determined before those of the other plan.
2. *Rules.* This plan determines its order of medical benefits using the first of the following rules which applies:
 - a. *Nondependent/dependent.* The medical benefits of the plan that covers the person as an employee, covered person or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.
 - b. *Dependent child/parents not separated or divorced.* Except as stated in c. below, when this plan and another plan cover the same child as a dependent of different persons, called "parents":
 - i. The medical benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - ii. If both parents have the same birthday, the medical *benefits* of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

- c. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, medical benefits for the child are determined in this order:
 - i. First, the plan of the parent with custody of the child;
 - ii. Then, the plan of the spouse of the parent with the custody of the child; and
 - iii. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay

or provide the medical benefits of the plan of that parent has actual knowledge of those terms, the medical 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 medical benefits are actually paid or provided before the entity has that actual knowledge.

- d. *Joint custody.* If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the *Order of medical benefit determination rules* outlined in b. above.
- e. *Active/inactive employee.* The medical 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 medical benefits, this rule is ignored.
- f. *Workers' compensation.* Coverage under any workers' compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer, before submitting them to Medica.
- g. *No-fault automobile insurance.* Coverage under the No-Fault Automobile Insurance Act or similar law applies first.
- h. *Longer/shorter length of coverage.* If none of the above rules determines the order of medical benefits, the medical benefits of the plan which covered an employee, covered person or enrollee longer are determined before those of the plan which covered that person for the shorter term.

Effect on the medical benefits of the Mayo Medical Plan

- 1. *When this section applies.* This section applies when, in accordance with *Order of medical benefit determination rules*, this plan is a secondary plan as to one or more other plans. In that event, the medical *benefits* of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in 2. immediately below.
- 2. *Reduction in this plan's medical benefits.* The medical benefits of this plan will be reduced when the sum of:
 - a. The medical benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
 - b. The medical 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 medical benefits of this plan will be reduced so that they and the medical benefits payable under the other plans do not total more than those allowable expenses.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

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

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

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

Right to Subrogation and Reimbursement

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

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

- You will cooperate with the plan in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the plan promptly, in writing, of any potential legal claim(s) you may have against any third party for acts which caused medical benefits to be paid or become payable.
 - Providing any relevant information requested by the plan.

- Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the plan's consent or the plan's agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

- The plan has first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Medical benefits paid by the plan may also be considered to be medical benefits advanced.

- If you receive any payment from any party as a result of sickness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting medical benefits from the plan, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets (to the extent of the amount of plan medical benefits provided on behalf of the covered person), and (ii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.
- The plan's rights to recovery will not be reduced due to your own negligence or comparative fault.
- Upon the plan's request, you will assign in writing to the plan all rights of recovery against third parties, to the extent of the medical benefits the plan has paid for the sickness or injury.
- The plan may, at its option, take necessary and appropriate action to preserve the plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund medical benefits as required under the terms of the plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the plan, without its written approval.
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs, next of kin or beneficiaries. In the case of your death the plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind unless the plan expressly agrees in writing.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs or next of kin, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.
- The plan and all administrators or their agents administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Harmful Use of Medical Services

If Medica or Alluma determines that you are receiving health services or prescription medications in a quantity or manner that may harm your health, Medica or Alluma 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 or Alluma 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 or Alluma may deny claims for health services or prescription medications you receive from a non-coordinating health care provider if such services and prescription medications 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 Medica Member Services at one of the telephone numbers listed at the front of this plan. Additionally, you have the right to appeal Medica's or Alluma's decision concerning the application of this section. See **How Do I Submit a Claim** for more information on your appeal rights.

How Do I Submit a Claim

All claims must be submitted to the plan and all claims review will comply with the rules and procedures in this **How Do I Submit a Claim** section. If you do not file a claim or follow the claim procedures, you are giving up important legal rights. This section is intended to comply with applicable law including Health Care Reform.

Important definitions and notes

Adverse Benefit Determination. A denial, reduction, or termination of a benefit, or a rescission or a failure to provide or make payment (in whole or in part) for a benefit or a rescission.

Authorized representative. A person designated by a claimant or this plan to act on behalf of a claimant.

Claimant. A person who believes he/she is entitled to benefits under this plan. In this **How Do I Submit a Claim** section, the term claimant shall also include a claimant's authorized representative, if applicable.

Concurrent care claim. A claim that requires prior authorization under the plan that is reconsidered after a course of treatment has been initially approved. There are two types of concurrent care claim: (1) where reconsideration by this plan results in a reduction or termination of coverage for a previously approved benefit; and (2) where an extension is requested by the claimant for coverage beyond the initially approved benefit.

External review. An independent review of an adverse benefit determination (following final appeal under the plan) under applicable state or federal external review procedures pursuant to Health Care Reform.

Independent Review Organization (IRO). An independent, accredited organization, contracted by the plan, but separate and apart from the plan, responsible for conducting external review of an adverse benefit determination.

Post-service claim. Any claim for a benefit under this plan that is submitted for payment or reimbursement after the services have been rendered.

Pre-service claim. Any claim for a benefit under the plan where receipt of the benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care. Benefits under the plan that are pre-service claims (i.e., subject to approval in advance) are listed in **Medical prior authorization** in the **Before You Access Medical Care** section as services that require prior authorization.

Urgent pre-service claim. An urgent pre-service claim is a type of pre-service claim. An urgent pre-service claim is any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or – in the opinion of a physician with knowledge of the claimant's medical condition – would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a physician with knowledge of the claimant's medical condition

determines that a claim is an urgent pre-service claim, the claim will be treated as an urgent pre-service claim.

- Unless specifically noted, oral inquiries about coverage and benefits are not considered claims or appeals.
- All time periods described in this section are in calendar days, not business days.
- Except as specifically noted, the claim procedure for pharmacy benefits is the same as for other medical benefits in the plan. For pharmacy benefits, the pharmacist is considered the health care provider and the prescription drug is considered the service or supply.
- This section does not apply to disputes related solely to paying for coverage pre-tax under the Pre-Tax Premium Rules and/or denials of requests to make changes to pre-tax elections during the year. If you have such a dispute, explain your concern in writing to the HR Connect. You will receive a written response.

Types of claims

The plan has four categories of claims as defined above. They are as follows:

- Concurrent care claim;
- Post-service claim;
- Pre-service claim; or
- Urgent pre-service claim.

Each category of claim has its own set of claim and appeal requirements. The primary difference between the categories of claims is the timeframes within which claims will be determined.

For the purpose of determining which claim and appeal procedures to follow, the claim type is determined initially. However, if the nature of the claim changes as it proceeds through the claim and appeal process, the claim can be re-characterized. For example, a claim may initially be an urgent pre-service claim. If the urgency subsides, it may be re-characterized as a pre-service claim. Once the services are rendered and submitted to the plan for payment, it becomes a post-service claim.

Authorized representative

- For the purpose of the plan's claims and appeal procedures, an authorized representative may act on a claimant's behalf with respect to any aspect of a claim or appeal.

How to file a claim

1. Post-service claims

A post-service claim must be filed within one (1) year following the date of service or from when a supply is received. Health care providers may submit post-service claims on a claimant's behalf. If a health care provider submits a post-service claim on a claimant's behalf, the health care provider will not be considered an authorized representative and

will not receive the notification described below in the case of an adverse benefit determination.

You are responsible for paying any coinsurance directly to the provider either at the time of your visit or when your provider sends you a bill for the amounts.

In some instances you may need to pay your provider or pharmacist in full and then submit a claim for reimbursement to Medica or Alluma at the address indicated in the chart at the end of this section. Claims for reimbursement, if approved, will be paid to you, not the provider.

A post-service claim must be submitted electronically or be in writing and submitted to:

Medical services claims	Prescription drug claims
Send your medical service claim form to the address found on the back of your ID card.	Complete the Prescription Drug Reimbursement Request Form at Allumaco.com/members: Alluma P.O. Box 14711 Lexington, KY 40512-4711 Or fax to: (608) 741-5475 You may also submit a claim electronically by logging in to Medica.com/Signin, then selecting Go to Alluma . On the Benefits menu, select Forms .

2. Post-service claim for medical services

A post-service claim for medical services or supplies should be filed on a universal billing form and must include the following information below:

- The name of the plan;
- The identity of the claimant, including name, address and date of birth;
- The date(s) of service;
- The name, National Provider Identification number, credentials, and tax identification number of the healthcare provider;
- The place of service;
- A specific diagnosis code (current International Classification of Disease, Clinical Modification (ICD, CM) format);
- A specific service code for which payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format);
- The amount of billed charges; and

- If a claimant has already paid for the medical service or supply and is requesting reimbursement, he/she must also submit proof of payment.

A medical services claim form can be found at Medica.com/SignIn for covered persons who are filing their own medical claims for reimbursement.

3. Pre-service claims (including urgent pre-service claims)

Typically, a pre-service claim is made on the claimant's behalf by the treating physician as an authorized representative. However, it is the claimant's responsibility to ensure that a pre-service claim has been filed. The claimant can accomplish this by having his/her healthcare provider contact Medica or Alluma to file a pre-service claim on behalf of the claimant.

A pre-service claim must be submitted to:

Medical services claims	Prescription drug claims
Medica Member Services PO Box 9310, Route 0501 Minneapolis, MN 55440-9310	Prior authorization for prescription drugs may be requested through the SureScripts or CoverMyMeds web portal electronically or through the provider's Electronic Health Record (EHR). Visit Allumaco.com/providers for additional information.

4. Urgent pre-service claims

This accelerated claim procedure applies if you are 1) seeking approval for a benefit that requires prior authorization and 2) you have not already received the service or supply.

An "urgent" claim is a claim for a benefit that requires prior authorization and a delay in treatment could either 1) seriously jeopardizes your life, health or ability to regain maximum function or 2) in the opinion of a physician with knowledge of your medical condition, cause you severe pain. If you or your authorized representative or physician believe that your claim is urgent, notify Medica or Alluma and provide the information you want considered regarding your claim.

A benefit requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization from the plan before receiving the service. If the benefit requires prior authorization but you receive the service or supply before obtaining the authorization, your benefit claim will be handled under the standard claim procedure.

Prior authorization is required for some services in the plan. Please review the list of services requiring prior authorization in **Medical prior authorization** in the **Before You Access Medical Care** section for your particular plan option.

Urgent pre-service claims and inpatient admissions where the underlying services do not require prior authorization may be submitted orally at the following phone numbers:

Providers **(800) 458-5512**; Covered persons **(866) 839-4015**.

- A pre-service claim for medical services or supplies must include the following information:
 - The name of the plan;

- The identity of the claimant, including name, address and date of birth;
 - The proposed date(s) of service;
 - The name and credentials of the healthcare provider;
 - An order or request from the healthcare provider for the requested service;
 - The proposed place of service;
 - A specific diagnosis;
 - A specific proposed service code for which approval or payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format); and
 - Clinical information for the plan to make a medical necessity determination.
- b. A pre-service claim for prescription drugs must include the following information:
- The name of the plan;
 - The identity of the claimant, including name, address and date of birth;
 - The name of the prescription drug requested;
 - The name and credentials of the healthcare provider prescribing the requested prescription drug;
 - A specific diagnosis; and
 - Clinical information for the plan to make a medical necessity determination.

5. **Incorrectly filed claim**

Failure to submit a claim to the proper place and/or in writing if required, may result in the claim being treated as an incorrectly filed claim. If a pre-service claim has been filed incorrectly, the plan will notify the claimant as soon as possible but no later than the timeframes stated below:

- a. ***Pre-service claims (not including urgent pre-service claims):*** no later than 5 days following receipt of the incorrectly filed claim.
- b. ***Urgent pre-service claims:*** no later than 24 hours following receipt of the incorrectly filed claim.

6. **Concurrent care claims**

Where an extension is requested for benefits beyond the initially approved benefit, a claimant should follow the instructions for how to file a pre-service claim.

7. **Incomplete claims**

- a. ***Pre-service claims and post-service claims (not including urgent pre-service claims)***

Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the

claimant is appropriately notified, the plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the claimant responds or should have responded.

The notification will include a timeframe of at least 45 days in which the necessary information must be provided. Once the necessary information has been provided, the plan will decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be denied.

b. **Urgent pre-service claims**

The plan will notify the claimant of an incomplete claim as soon as possible, but not later than 24 hours following receipt of the incomplete claim. The notification will describe the information necessary to complete the claim and specify the timeframe of at least 48 hours within which the claim must be complete. Notification may be made orally to the claimant or the healthcare provider, unless the claimant requests written notice. The plan will make a claim determination as soon as possible but not later than the earlier of 1) 48 hours after receipt of the specified information, or 2) the end of the period of time provided to submit the specified information.

8. Notification of claim decisions

a. **When the plan will provide notification of a claim determination**

Medica or Alluma has 30 days to decide your claim and notify you if your claim is denied in whole or in part. If your claim is denied, the notice will contain the information required by federal regulations.

You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of Medica or Alluma. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide the information will not count against the time Medica or Alluma has to make its decision.

- I. ***Post-service claims and concurrent care claims:*** Notification will be provided only if the decision is an adverse benefit determination within 30 days after receipt of claim.**
- II. ***Pre-service claims (including urgent pre-service claims) request:*** Notification will be provided whether the claim or request is approved or denied within 30 days after receipt of claim (within 72 hours after receipt of claim for urgent pre-service claims).**

**Insufficient information timeframe

b. **Content of notification**

- I. ***Adverse benefit determination:*** Notice of an adverse benefit determination will be provided in written or electronic form in a culturally and linguistically appropriate manner. For urgent pre-service claims, notification will be provided orally to the claimant within the timeframe described above and written or

electronic notification will be furnished not later than 3 days after the oral notification. A plan decision to rescind coverage shall be considered and treated as an adverse benefit determination.

The notification will include the following:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;
- A description of the plan procedures and time limits for appeal of the adverse benefit determination and the right to sue in federal court;
- Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination or a statement that such information was relied upon in making the adverse benefit determination and will be provided free of charge upon request;
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Disclosure of the availability of, and contact information for, any applicable office of health coverage consumer assistance or ombudsman to assist covered persons with the internal claims process and appeals and external review process.

- II. ***Not adverse decision:*** For pre-service claim and urgent pre-service claim determinations that are not adverse, notice that the request for prior authorization has been approved will be provided to the healthcare provider in most circumstances.

9. Special rule for claims related to course of treatment

If you are notified that a benefit you were granted for a specified period of time or number of treatments will be reduced from what was previously granted, the notice is considered a claim denial and will be provided to you sufficiently in advance of the benefit reduction to allow you to file an appeal. If you were granted treatment for a specified time or number of treatments, and you request an extension of that course of treatment within 24 hours before the treatment ends, you will be notified within 24 hours whether the extension is approved or denied. If you request the extension less than 24 hours before the treatment ends, your request will be processed as shown on the chart above depending on whether the claim is urgent or non-urgent.

Appeals Process

Health Care Reform requires appeal procedures for adverse benefit determination under which claimants receive full and fair review of the claim and adverse benefit determination. The following will apply to all types and levels of appeals of adverse benefit determinations:

1. ***Right to review claim file:*** The claimant will have the right to review his or her claim file.
2. ***Submission and consideration of comment:*** The claimant will have the right to present "evidence and testimony" as that phrase is clarified through regulatory guidance. The claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the adverse benefit determination will take into account all information, whether or not presented or available for the initial determination. No defense will be given to the prior determination.
3. ***Disclosure of new or additional evidence:*** Claimant will be provided, as soon as possible, any new or additional evidence considered relied upon, or generated by or at the direction of the plan free of charge and pursuant to the regulatory guidance.
4. ***Disclosure of new or additional rationale:*** Claimant will be provided, as soon as possible, any new or additional rationale for the adverse benefit determination free of charge pursuant to regulatory guidance.
5. ***Decision:*** The review will be made by a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.
6. ***Consultation with independent medical expert:*** In the case of a claim denied on the grounds of a medical judgment, a healthcare provider with appropriate training and experience will be consulted. The healthcare provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

Filing an appeal

1. If there is an adverse benefit determination, the claimant may request a review by Medica or Alluma by filing an appeal. The claimant must file an appeal within 180 days after the date the claimant receives notice that the claim is denied.

Medical appeal requests must be in writing and submitted to:

Medica
Member Services
PO Box 9310, Route 0501
Minneapolis, MN 55440-9310

Pharmacy appeal requests must be in writing and submitted to:

Alluma
Attn: Appeals
P.O. Box 14651
Saint Louis, MO 63166

Fax: (833) 951-1683

Secure email: Allumaclinical@allumaco.com

2. Special rule for expedited review of urgent pre-service claims

A claimant may request an expedited review orally or in writing and all necessary information (including the plan's benefit determination on review) will be transmitted by telephone, facsimile or other available expeditious method.

An appeal must include the following information:

- The name of the plan;
- The identity of the claimant, including name, address and date of birth;
- Information regarding the claim request being appealed, such as:
 - A copy of the adverse benefit determination notice the claimant received or other information to identify the claim; and
 - A statement that the claimant is requesting an appeal;
- An explanation of why an appeal is being requested, including the particular aspect of the adverse benefit determination the claimant is disputing; and
- Supporting documentation.

An appeal of an adverse benefit determination must be submitted to the plan within 180 days following receipt of a notification of an adverse benefit determination of a claim. *If an appeal is not requested within these 180 days, the claimant loses the right to appeal.*

3. Timeframes for appeals

A claimant may voluntarily agree to extend the timeframes specified below for the plan to make a decision.

- **Post-service claims:** The plan will make a determination no later than 60 days from the date the appeal was received.
- **Pre-service claims:** The plan will make a determination no later than 30 days from the date the appeal was received.
- **Urgent pre-service claims:** The plan will make a determination no later than 72 hours from the date the appeal was received.
- **Concurrent care claims:** For a reduction or termination of coverage for a previously approved benefit, the plan will make a determination sufficiently in advance to allow the claimant to file an appeal and obtain a determination before the benefit is reduced or terminated.

Where an extension is requested by the claimant for coverage beyond the initially approved benefit:

- If the request meets the definition of an urgent pre-service claim, the plan will make a determination no later than 72 hours from the date the appeal was received.
- If the request meets the definition of a pre-service claim, the plan will make a determination no later than 30 days from the date the appeal was received.

- If the request meets the definition of a post-service claim, the plan will make a determination no later than 60 days from the date the appeal was received.

4. Notification of appeal decisions

Written or electronic notification of the plan's determination will be provided in a culturally and linguistically appropriate manner to the claimant for all appeals.

For adverse benefit determinations, the notification will include the following:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the claimant's claim for benefits;
- A statement regarding additional levels of appeal (if any) and the right to sue in federal court;
- Disclosure of an internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Information sufficient to identify the claim involved;
- Notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- A description of the plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and the external appeals process.

For decisions that are not adverse, a notice will be provided that informs the claimant the decision has been reversed, and the claim has been approved.

Filing a request for standard external review

If there is an adverse benefit determination by the plan that involves a medical judgement (including, but not limited to, medical necessity or experimental/investigative determinations), related to a surprise medical or air ambulance bill under the No Surprises Act, or relates to an appeal of a rescission of a claimant's coverage, the claimant may request an external review after exhausting internal appeals under the plan.

Medical standard external review requests must be in writing and submitted to:

Medica
Member Services
PO Box 9310, Route 0501
Minneapolis, MN 55440-9310

Pharmacy standard external review requests must be in writing and submitted to:

Alluma
Attn: Appeals
P.O. Box 14651
Saint Louis, MO 63166

Fax: **(833) 951-1683**

Secure email: **Allumaclinical@allumaco.com**

An external review must include the following information:

- The name of this plan;
- The identity of the claimant, including name, address and date of birth;
- Information regarding the appeal being requested for an external review, such as a copy of the appeal denial letter;
- A statement that the claimant is requesting an external review;
- An explanation of why an external review is being requested, including the particular aspect of the adverse benefit determination being disputed; and
- Supporting documentation.

Generally, an external review of an adverse benefit determination must be submitted to this plan within four (4) months following the date of receipt of a notice of a final internal adverse benefit determination. There are a very limited number of circumstances where an external review can be requested prior to a final internal adverse benefit determination. Please contact Medica or Alluma for more information.

Claimants may not request an external review after the expiration of the four (4) month period.

1. Timeframes for preliminary review of request for standard external review

Within five (5) business days following the date of receipt of the external review request, Medica or Alluma will complete a preliminary review of the request to determine whether:

- Claimant is (or was) covered under the plan at the time the health care item or service was requested or provided;
- The adverse benefit determination or the final internal adverse benefit determination is not based on the fact that claimant was not eligible for coverage under the plan;
- Claimant has exhausted the plan's internal appeal process (unless exhaustion is not otherwise required); and
- Claimant has provided all the information required to process an external review.

Within one (1) business day of the completion of its preliminary review, Medica or Alluma (or its designated Independent Review Organization (IRO)) will notify the claimant of the results of the preliminary review.

If claimant's request is eligible for external review, a notice will be sent informing claimant of eligibility for external review. Claimant's request is assigned by Medica or Alluma to an IRO to conduct the external review. The plan will contract with at least three (3) IRO's, and Medica or Alluma will rotate the external reviews among the IRO's.

If claimant's request is complete but **not** eligible for external review, a notice will be sent informing claimant of *non-eligibility* for external review. The notice will state the reasons for the request not being eligible for external review and will provide contact information for the Employee Benefits Security Administration, toll free number **(866) 444-EBSA (3272)**.

If claimant's request is **incomplete**, a notice will be sent to the claimant. The notice will describe the information, materials, etc. needed to complete the request. The claimant will then be provided time to complete the request during the greater of:

- The initial four month period within which to request an external review, or
- 48 hours (or as identified in the notice) after the receipt of the notice.

2. External review process conducted by Independent Review Organization (IRO)

Upon assignment by Medica or Alluma, the IRO conducts the external review of the adverse benefit determination.

As part of their review, the IRO will utilize experts when appropriate to make determinations regarding the services being disputed. In addition, the IRO, when making their decision, may request additional information such as reports from appropriate health care professionals, evidence-based guidelines and any applicable clinical review criteria developed and used by Medica or Alluma.

3. Timeframes for Independent Review Organization determination

Within 45 days after the IRO receives the request for external review, the IRO will provide written notice of the final external review decision.

4. Filing a request for an expedited external review

Under certain circumstances, an expedited external review may be requested. Claimants may request an expedited external review when:

- An adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal of an urgent pre-service claim would seriously jeopardize the claimant's life, health or ability to regain maximum function, and a request for an expedited internal appeal of an urgent pre-service claim has been filed; or
- A final internal adverse benefit determination involves a) a medical condition where the timeframe for completing a standard internal review would seriously jeopardize the claimant's life, health or ability to regain maximum function, or b) an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Medical expedited external review requests must be in writing and submitted to:

Medica
Member Services
PO Box 9310, Route 0501
Minneapolis, MN 55440-9310

Pharmacy expedited external review requests must be in writing and submitted to:

Alluma
Attn: Appeals
P.O. Box 14651
Saint Louis, MO 63166

Fax: **(833) 951-1683**

Secure email: **Allumaclinical@allumaco.com**

An expedited external review request must include the following information:

- The name of this plan;
- The identity of the claimant, including name, address and date of birth;
- Information regarding the appeal being requested for an external review, such as a copy of the appeal denial letter;
- A statement that the claimant is requesting an external review;
- An explanation of why an external review is being requested, including the particular aspect of the adverse benefit determination being disputed; and
- Supporting documentation.

5. Timeframe for preliminary review of request for an expedited external review

Immediately upon receipt of the request for an expedited external review, Medica or Alluma will determine whether the request meets the eligibility requirements for a standard external review (described above under the **Timeframes for preliminary review of request for standard external review** section). Medica or Alluma will immediately notify claimant of external review eligibility.

The claimant will be notified by Medica or Alluma or its designated IRO of the results of the preliminary review.

If a claimant's request is eligible for expedited external review, a notice will be sent informing claimant of eligibility for expedited external review. Claimant's request is assigned by Medica or Alluma to an IRO to conduct the expedited external review.

The plan will contract with at least three (3) IRO's and Medica or Alluma will rotate the expedited external reviews among the IRO's.

If a claimant's request is complete but not eligible for external review, a notice will be sent informing claimant of non-eligibility for external review. The notice will state the reasons for the request not being eligible for external review and will immediately provide contact

information for the Employee Benefits Security Administration, toll free number **(866) 444-EBSA (3272)**.

If a claimant's request is incomplete, a notice will be sent to the claimant. The notice will describe the information, materials, etc. needed to complete the request. The claimant will then be provided time to complete the request.

6. Expedited external review process conducted by Independent Review Organization (IRO)

Upon assignment by Medica or Alluma, the IRO conducts the expedited external review of the adverse benefit determination.

As part of their review, the IRO will utilize experts when appropriate to make determinations regarding the services being disputed. In addition, the IRO, when making their decision, may request additional information such as reports from appropriate health care professionals, evidence-based guidelines and any applicable clinical review criteria developed and used by Medica or Alluma.

7. Timeframes for Independent Review Organization expedited determination

As expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited external review, the IRO will provide written notice to claimant and the plan of the final expedited external review decision.

If the IRO's notice of final expedited external review decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.

How Medical Providers are Paid

Medical network providers

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

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

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

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

In certain risk-sharing payment arrangements, the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per covered person or an amount per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a covered person's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a covered person's health services, the network provider may keep some of the excess. In other risk-sharing arrangements, the network accepts a portion of the financial risk for the provision of covered services to all covered persons enrolled in a particular plan product.

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

Withhold arrangements

For some network providers paid on a fee-for-service basis, some of the payment is held back. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15 percent of the fee schedule amount. In general, a portion of network hospitals' fee-for-service payments is not held back. However, when it is, the withhold amount will not usually exceed 5 percent of the fee schedule amount.

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

the network provider's contract, including but not limited to quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network medical providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, you are responsible for paying the difference.

Additional Terms of Your Coverage

This section describes the general provisions of the plan.

Examination of a covered person

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

Clerical error and misstatements

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

Family and Medical Leave Act of 1993 (FMLA)

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

Relationship between parties

The relationships between Medica, the sponsor and medical network providers are contractual relationships between independent contractors. Medical network providers are not agents or employees of Medica. The relationship between Alluma, the Mayo Medical Plan and the leased pharmacy network are contractual relationships between independent parties. Pharmacy network providers are not agents or employees of Alluma. The relationship between a provider and any covered person is that of health care provider and patient. The provider is solely responsible for health care provided to any covered person.

Definitions

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

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.

Alluma Care formulary. An approved, continually updated list of medications, criteria for utilization and dosage recommendations supplemented with drug monographs or references. The Mayo Clinic Pharmaceutical Formulary Subcommittee develops the formulary which is centered on meeting the needs of the patient for drug safety, effectiveness and value.

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

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

Benefits. Benefits collectively refers to both the medical and pharmacy health services or supplies (described in this plan and any subsequent amendments) approved by Medica or Alluma as appropriate as eligible for coverage.

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

Biosimilar. A biologic drug that is highly similar to an approved reference drug. Biosimilars have no clinical meaningful differences in terms of quality, safety or efficacy from the original biologic drug.

Brand name drug. A patent-protected prescription drug.

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

Claims administrator. The claims administrator who administer claims for benefits under the plan. Medica serves as the Claims Administrator for the Mayo Medical Plan, and Alluma serves as the Claims Administrator for the prescription drug component of the plan. More information regarding the claims administrators for medical and pharmacy benefits, can be found inside the front cover or on the back of your ID card or in **How Do I Submit a Claim**.

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

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

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

When the wholesale amount is not known nor readily calculated at the time the medical 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 covered person under the plan.

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

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

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

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

Pharmacy coinsurance amounts vary by formulary tier and the pharmacy dispensing the medication. Please see **Pharmacy and Prescription Medications** for more information.

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

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

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

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

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

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

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

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

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

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.

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

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

Enrollee. An employee who the plan administrator determines is enrolled under the plan.

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

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

Generic drug. A prescription drug that has lost patent exclusivity. FDA A-rated generic drugs (which are the only type of generic drugs covered under the Alluma Care formulary) contain the same active ingredient as the brand name drug, are manufactured under the same FDA standards, and are considered equivalent in all respects to the brand name drug.

Genetic testing. An analysis of human DNA, RNA, chromosomes, proteins or metabolites, if the analysis detects genotypes, mutations or chromosomal changes. Genetic testing includes pharmacogenetic testing. Genetic testing does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition. For example, an HIV test, complete blood count or cholesterol test is not a genetic test.

GLP-1. An abbreviation for a class of medications called glucagon-like peptide-1 receptor agonists. This group of medications is indicated for Type 2 diabetes and weight management, as well as a growing list of other conditions. In some products, a GLP-1 is combined with other ingredients, such as glucose-dependent insulinotropic polypeptides (GIPs).

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

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

Inpatient. An uninterrupted stay, following formal admission to a hospital, skilled nursing facility or licensed acute care facility.

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

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II or III trials;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals or the reports of clinical trial committees and other technology assessment bodies; and

3. Whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

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

At Mayo Medical Plan's sole discretion, it may from time to time allow coverage of certain services conducted at Mayo facilities where (1) is satisfied and there is a consensus of opinion by Mayo physicians who typically manage the condition.

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

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.

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

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

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

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

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

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

Mental health residential treatment services. Consistent with the covered person’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. A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health practitioner
 - b. On-site or virtual psychiatric assessment within 48 hours of admission;
 - c. Psychiatric follow-up visits at least once per week provided by a licensed psychiatric prescriber for mental health treatment;
 - d. Individual and or family therapy a minimum of once weekly provided by a licensed mental health professional for mental health treatment;
 - e. Weekly client education (e.g. mindfulness, reflective journaling);
 - f. Other services specific to mental health treatment;
 - g. Adequate nursing coverage for the specific level of care; and
 - h. A written, specific and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility or pharmacy) that has entered into a written agreement with Medica or Alluma’s subcontractor, as applicable or has made other arrangements with Medica or Alluma to provide medical benefits to you. The medical and pharmacy networks are identified online in your plan’s provider directory. The participation status of providers will change from time to time.

The medical network provider directory will be furnished automatically, without charge and it may be obtained by signing in at **Medica.com/SignIn** or by contacting Medica Member Services at one of the telephone numbers listed inside the front cover or on the back of your ID card. Pharmacy network providers may be identified at **Medica.com/SignIn**.

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

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

Non-network provider reimbursement amount. The amount that the plan will pay to a non-network provider for each medical 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 Medica 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 medical benefits, you must pay a portion of the non-network provider reimbursement amount as a copayment or coinsurance.

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

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

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

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by the plan, or charge in excess of the non-network provider reimbursement amount,

charge you pay in addition to your deductible. The difference in cost between a generic and brand name prescription medication when you or your provider choose the brand name when a chemically equivalent generic is available, and the coinsurance for non-preferred (Tier 3) drugs also do not apply to the annual out-of-pocket maximum.

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

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

Pharmacy benefits. The pharmacy services or supplies (described in this plan and any subsequent amendments) approved by Alluma as eligible for coverage.

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.

Plan. The Mayo Medical Plan, as may be amended in the future.

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

Plan administrator. The Salary & Benefits Committee.

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. Medications and drugs that bear the legend, "Federal law prohibits dispensing without a prescription." This term includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a physician or other authorized health care provider and are approved by the FDA. Insulin and diabetic supplies (e.g., syringes, lancets and testing strips) are generally covered as prescription drugs as well.

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

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the covered person 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 covered persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. With respect to covered persons who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the HRSA (including Food and Drug Administration approved contraceptive methods and sterilization procedures other than prescription drugs and related patient education and counseling).

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

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

Professionally administered drugs. Drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as drugs that, according to the manufacturer's recommendations, must typically be administered by a health care provider.

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

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

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

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

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

Retiree. An individual who satisfies the requirements under the **Medical coverage in retirement in Introduction**.

Routine foot care. Services that are routine foot care may require treatment by a professional and include but are not limited to any of the following:

1. Cutting, paring or removing corns and calluses;
2. Nail trimming, clipping or cutting; and
3. Debriding (removing toenails, dead skin or underlying tissue).

Routine foot care may also include hygiene and preventive maintenance such as:

1. Cleaning and soaking the feet; and
2. Applying skin creams in order to maintain skin tone.

Routine patient costs. All items and services that would be covered benefits if not provided in connection with a clinical trial. In connection with a clinical trial, routine patient costs do not include an investigative or experimental item, device or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

Sponsor. Mayo Clinic.

Substance use condition (also sometimes referred to as “substance use disorder”).

Includes all conditions covered under the plan that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the *International Classification of Diseases (ICD)* or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most

current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This definition shall be used to determine “substance use” benefits as set forth in this plan.

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. A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health professional;
 - b. Completion of a substance use disorder or chemical health assessment;
 - c. Access to psychiatric services provided by a licensed psychiatric prescriber for mental health treatment as clinically indicated for substance use disorder treatment;
 - d. 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;
 - e. Weekly client education (e.g. mindfulness, reflective journaling, sleep hygiene, anger management or safe sex practices);
 - f. Other services specific to mental health treatment and or substance use disorder treatment;
 - g. Adequate nursing coverage for the specific level of care; and
 - h. A written, specific and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Telehealth. Telehealth or sometimes referred to as “telemedicine”. Telehealth is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An originating site means a site at which a patient is located at the time the services are provided by means of telehealth. A distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of telehealth. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telehealth consultations or services.

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

Virtual care. Professional evaluation and medical management services provided to patients, in locations such as their home or office, through email, telephone or webcam. Virtual care is used to address non-urgent medical symptoms for covered persons describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not

include telephone calls for reporting normal lab or test results or solely calling in a prescription to a pharmacy.

Waiting period. The period of time that must pass before an otherwise eligible employee and/or dependent is eligible to become covered under the plan (as determined by the sponsor's eligibility requirements). However, if an eligible employee or dependent enrolls through either an open enrollment period or a special enrollment period further described in the General Information Booklet, any period before such open or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Signature

IN WITNESS WHEREOF, the _____ (title) of the sponsor has
executed the foregoing plan on behalf of sponsor on this _____ day of _____
_____, _____.

By: _____
(please print)

(signature)

Its: _____
(title)

(date)

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