MEDICA®

MEDICA CHOICE PASSPORT

PLAN DOCUMENT

Administered by Medica Self-Insured

DUNN COUNTY WISCONSIN

MEDICA CHOICE PASSPORT

3000-0% HSA

BPL #94177

GROUP #25343

JANUARY 1, 2020

(AMENDED)

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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

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

နေမှန်အဲဗီ။ တက်ကြွထံစေ၊ကလီနွမ်နေ၊တက်ဂုဂ်တက်ကျိုး၊အံ၊လေ၊အကလီနွမ်, ကိုးလီတစ်ဒီနိုဂ်ဂ်ကိ၊လေ၊အပဉ် ယုဉ်လေ၊လဲာ်တီလဲာ်စီအပူ၊အံ၊မှတမှ်ဖဲနနွိုင်ခေလဲာ်ဆုဉ်သးဒေကုအလိ၊ခ်ံတကပ၊အဒီဒိုဉ်မ္ဘည်တကျာ်.

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

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

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

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

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

MEDICA CUSTOMER SERVICE

The specific customer service phone number for your plan is found on the back of your ID card.

General Customer Service:

1-800-952-3455

TTY Users: National Relay Center: 711
then ask them to dial Medica at
1-800-952-3455

Find more information about your benefits by logging on to mymedica.com.

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Welcome!

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

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

Some terms used have specific meanings.

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

Where to Find It

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

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

Do you need…	***Read section(s):***
• Physician services (doctor charge)	Physician and Professional Services
Services provided during a hospital stay? • Anesthesia services • Hospital services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Mental health or behavioral health services? • Inpatient services • Office visit	Behavioral Health – Mental Health
Substance abuse services? • Inpatient services • Office visit	Behavioral Health – Substance Abuse
Pregnancy care services? • Breast pumps • Inpatient services • Postnatal services • Prenatal services	Durable Medical Equipment, Prosthetics and Medical Supplies Pregnancy – Maternity Care
Medical supplies or equipment? *Examples: crutches, CPAP, wheelchair, oxygen* • Insulin pumps and related supplies • Durable medical equipment and medical supplies • Hearing aids • Prosthetics	Durable Medical Equipment, Prosthetics and Medical Supplies
Medical-related dental care? • Accident-related dental services • Oral surgery • Treatment of temporomandibular joint (TMJ) and craniomandibular disorder	Medical-Related Dental Services Temporomandibular Joint (TMJ) and Craniomandibular Disorder
Help recovering? *Example: Help received after a hospital stay, injury or surgery* • Home health care services • Physical, speech and occupational therapies • Skilled nursing facility services	Home Health Care Physical, Speech and Occupational Therapies Skilled Nursing Facility

The following amendment has been incorporated into this Plan Document:

- 20DunnCountyEyeglassPP, effective 1/1/20

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Introduction

Dunn County Wisconsin (sponsor) has established the Dunn County Employee Medical Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Dunn County Wisconsin (plan administrator). This plan was originally established January 1, 1985. This restatement of the plan is effective January 1, 2020, unless specifically stated otherwise.

The plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code) and applicable Wisconsin law.

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

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

How you accept coverage

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

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

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

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

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

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

If you need language interpretation

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

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

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

Medica's nondiscrimination policy

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

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

Plan Overview

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

General plan information

Plan Name

Dunn County Employee Medical Plan

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

Dunn County Wisconsin
800 Wilson Avenue
Menomonie, WI 54751
(715) 232-2429

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

Dunn County Wisconsin
800 Wilson Avenue
Menomonie, WI 54751
(715) 232-2429

Agent for Service of Legal Process

County Manager

Sponsor IRS Employer Identification Number (EIN)

39-6005690

Plan Year

January 1 through December 31

This is also your record keeping year.

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits

provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network, claims processing services and complaint resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from the general assets of sponsor. You may be responsible for a portion of the cost of the coverage provided under this plan.

Benefits

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

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

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

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). With

some exceptions, protected health information or PHI is information that: (i) identifies or could reasonably be used to identify you and (ii) relates to your physical or mental health or condition, the provision of your health care or your payment for health care. The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

1. The sponsor will not use or further disclose such PHI other than as permitted or required by this plan or as required by law (as defined in the HIPAA privacy standards).
2. The sponsor will ensure that any agents, including a subcontractor, to whom the sponsor provides PHI received from the plan or from another party acting on behalf of the plan, agree to the same restrictions and conditions that apply to the sponsor with respect to such PHI.
3. The sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsor, except under an authorization which meets the requirements of the HIPAA privacy standards.
4. The sponsor will report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the sponsor becomes aware.
5. The sponsor will make available PHI in accordance with your right of access under the HIPAA privacy standards.
6. The sponsor will make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA privacy standards.
7. The sponsor will make available the information required to provide an accounting of certain disclosures of PHI in accordance with the HIPAA privacy standards.
8. The sponsor will make its internal practices, books and records relating to the use and disclosure of PHI received from the plan or another party on behalf of the plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA privacy standards.
9. If feasible, the sponsor will return or destroy all PHI received from the plan, or another party acting on behalf of the plan, that the sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:

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

       HR Director, HR/RM Coordinator, County Manager

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

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

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

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

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

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

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

Before You Access Care

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

What you must do to receive benefits

Each time you receive health services, you must:

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

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

Provider network

In-network benefits are available through your plan's provider network. To see which providers are in your plan's network, check the online search tool on mymedica.com or contact Customer Service. Certain providers may be in other Medica networks, but not in your network.

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

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

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

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payments to such nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed) or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services

with no additional billing to the enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

Prior authorization

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

Emergency services do not require prior authorization.

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

You, someone on your behalf or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Medica to request prior authorization for a service or supply. If a network provider fails to request prior authorization after you have consulted with them about services requiring prior authorization, you will not be penalized for this failure.

You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider.

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

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

- Solid organ and blood and marrow transplant services - this prior authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- Certain reconstructive or restorative surgery procedures;
- Certain drugs and biologics;
- Certain home health care services;
- Certain medical supplies and durable medical equipment;
- Certain mental health services;
- Certain substance abuse services;
- Certain outpatient surgical procedures;

- Certain genetic tests;
- Certain imaging services;
- Non-emergency licensed air ambulance transportation; and
- Skilled nursing facility services.

Pregnancy/maternity care services do not require prior authorization and will be covered at the appropriate in-network or out-of-network benefit level.

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

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

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

Medica will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within 5 business days of the date your request was received if your request is for an experimental procedure and within 10 business days after the date your request was received for all other requests, 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 File a Complaint**.

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

Referrals to non-network providers

To receive in-network benefits for services received from a non-network provider, you will need to follow the steps described below. If you receive services from a non-network provider without following these steps, your out-of-network benefits will apply. For more information, see the tip sheet at medica.com/membertips.

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

What you must do:

1. Request a referral or standing referral* from a network provider to receive medically necessary services from a non-network provider. The referral will be in writing and will:
   a. Indicate the time period for when services must be received; and
   b. Specify the service(s) to be provided; and
   c. Direct you to the non-network provider selected by your network provider.
2. Ask your network provider to request prior authorization from Medica. Medica does not guarantee coverage for services that are received before you receive prior authorization.
3. If Medica approves the prior authorization request, your in-network benefit will apply.
4. Pay any amounts that were not approved for coverage by Medica.

*A standing referral is a referral issued by a network provider and authorized by Medica for conditions that require ongoing services from a specialist. Standing referrals will only be authorized for the period of time appropriate to your medical condition. To request a standing referral, contact Customer Service. If Medica denies your request for a standing referral, you have the right to appeal this decision as described in **How Do I File a Complaint**.

Medica:

1. May require that you see another network provider that Medica selects before determining that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.
3. Will provide coverage for health services that are:
   a. Otherwise eligible for coverage under this plan; and
   b. Recommended by a network physician.
4. Will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within ten business days of receiving your request, provided that all information reasonably necessary to make a decision has been given to Medica.

However, Medica will respond within a time period not exceeding 72 hours from the time of the initial request if: 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

Visiting non-network providers and why you pay more

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

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

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

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

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

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

Example:

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

Assumptions:

1. You have previously fulfilled your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. The plan's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally a percentage coinsurance. In this example, we will use 40% coinsurance.

b. In addition, the non-network provider will likely bill you for the difference between what they charge and the amount that the plan pays them.

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

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

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

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

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

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

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

When do I need to submit a claim

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

Continuity of care

In certain situations, you have a right to continuity of care. To request this, or if you have questions about how this may apply to you, call Customer Service at one of the telephone numbers listed at the front of this plan.

In-network benefits will continue to apply to health services you received from a provider who terminates his/her participation with Medica if that provider was listed as a network provider in the provider directory at your last enrollment period or your last coverage renewal period, for the following periods of time:

1. For health services received from a primary care physician whom you have chosen to receive services from and who is no longer a network provider, until the end of your current plan year as stated in your plan.
2. For health services received from any other type of provider whom you have chosen to receive services from and who is no longer a network provider, for the remainder of your course of treatment for which care was being received at the time of termination or for 90 days after such provider's participation terminates, whichever is less, provided it does not extend beyond the end of your current plan year as stated in your plan.

3. If your course of treatment is maternity care and you are in the second or third trimester of pregnancy, health services may be continued to be provided by the terminated provider through the completion of postpartum care.

In-network benefits will not continue to be applied to health services you receive from a provider:

1. Whose contract is terminated for misconduct on the part of the provider; or
2. Who is no longer practicing in Medica's geographic service area.

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

Coverage will not be provided for services or treatments that are not otherwise covered under the plan.

What's Covered and How Much Will I Pay

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

Important information about your benefits

- Before you receive certain services or supplies, you will need to get prior authorization from Medica. To find out when you need to do this, see **What to keep in mind** after each benefit section or call Customer Service at one of the telephone numbers listed at the front of this plan. Also refer to **Before You Access Care** for more information about the prior authorization process.
- When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.
- Certain benefits in this plan have limits. These limits might include day limits, visit limits or dollar limits. These limits are noted in this plan and apply whether or not you have met your deductible.

Key concepts

Deductibles

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

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

Out-of-pocket maximum

Your out-of-pocket maximum is an accumulation of 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 you pay in addition to your deductible or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.**

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

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUM

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximum		
	Your cost if you visit a:	
	Network provider:	**Non-network provider:**
Coinsurance	See specific benefit for applicable coinsurance.	
Deductible		
Per covered person	$3,000	$3,500
Per family	$6,000	$7,000
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		
Per covered person	$3,000	$3,500
Per family	$6,000	$7,000
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 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	Unlimited

AMBULANCE

Ambulance		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Emergency ambulance services or emergency ambulance transportation	Nothing after deductible	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: a. Transportation from hospital to hospital when: i. Care for your condition is not available at the hospital where you were first admitted; or ii. Required by Medica b. Transportation from hospital to skilled nursing facility	Nothing after deductible	0% coinsurance after deductible

What's covered

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

What to keep in mind

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

Non-emergency ambulance transportation that's arranged through an attending physician is eligible for coverage when certain criteria are met. Prior authorization (approval in advance) is required before you receive non-emergency licensed air ambulance transportation.

What's not covered

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

ANESTHESIA

Anesthesia		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Anesthesia services received during an office visit	Nothing after deductible	0% coinsurance after deductible
2. Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	0% coinsurance after deductible
3. Anesthesia services received during an inpatient stay	Nothing after deductible	0% coinsurance after deductible

What to keep in mind

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

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

AUTISM SPECTRUM DISORDER SERVICES

Autism Spectrum Disorder Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Intensive-level services for the treatment of autism spectrum disorders provided to a covered person who: a. Has a primary verified diagnosis of autism spectrum disorder; b. Commences intensive-level services after the age of two and before the age of nine; c. Has a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month time period with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed, continually measured and address the characteristics of autism spectrum disorder; d. Is present and engaged in the intervention;	Nothing after deductible	0% coinsurance after deductible

Autism Spectrum Disorder Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
e. Has a parent or legal guardian who is present and engaged during the majority of the treatment; f. Is provided evidence-based behavioral intensive therapy, treatment and services in an environment conducive to achieving the treatment plan goals; g. Is treated only by qualified providers, supervising providers, professionals, therapists or paraprofessionals; h. Is directly observed by the qualified provider at least once every two months, or as required by your plan's designated autism spectrum disorder provider Evidence-based behavioral therapy that was provided to the child for an average of 20 or more hours per week over a continuous six-month period is considered intensive-level services.		

Autism Spectrum Disorder Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
2. Nonintensive level services for the treatment of autism spectrum disorders provided to a covered person who: a. Has a primary verified diagnosis of autism spectrum disorder; b. Has completed intensive-level services for the treatment of autism spectrum disorder or has not and will not receive intensive-level services, but for whom nonintensive level services will improve the covered person's condition; c. Has a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders;	Nothing after deductible	0% coinsurance after deductible

Autism Spectrum Disorder Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
d. Is present and engaged in the intervention; e. Is provided treatment and services by qualified providers, supervising providers, professionals, therapists or paraprofessionals in an environment most conducive to achieving the goals of the treatment plan; f. The covered person's family is actively involved in team meetings and is provided training and consultation to implement the therapeutic goals of the treatment team.		

What's covered

Services to diagnose and treat autism spectrum disorders are covered.

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

What to keep in mind

Your plan's designated autism spectrum disorder provider arranges in-network autism spectrum disorder benefits and will refer you to other autism spectrum disorder providers only if network providers cannot provide the services you require. Call your plan's designated autism spectrum

disorder provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

Medica requires prior authorization (approval in advance) before you receive certain autism spectrum disorder services. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

The following definitions apply for purposes of autism spectrum disorder services:

- "Autism spectrum disorder" means autism disorder, Asperger's syndrome or pervasive development disorder not otherwise specified.
- "Intensive-level services" means evidence-based behavioral therapies that are directly based on, and related to, an individual's therapeutic goals and skills as prescribed by a physician familiar with the individual. Intensive-level services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills and is concomitant with evidence-based behavioral therapy. Coverage for speech therapy and occupational therapy is described in **Physical, Speech and Occupational Therapies**.
- "Nonintensive level services" means evidence-based therapy that occurs after the completion of treatment for intensive-level services or for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.
- "Qualified provider," "qualified paraprofessional," "qualified professional," "qualified supervising provider," "qualified intensive-level provider," "qualified intensive-level professional" and "qualified therapist" have the meanings set forth in Ins. 3.36 Wis. Admin. Code.

For in-network benefits:

- Your plan's designated autism spectrum disorder provider arranges in-network autism spectrum disorder benefits. You will be referred to other autism spectrum disorder providers only if network providers cannot provide the services you require.

For out-of-network benefits:

- Autism spectrum disorder services from a non-network provider listed below will be eligible for coverage under out-of-network benefits.
- You must receive services directly from or at any of the following non-network providers who are qualified to provide intensive-level services or nonintensive level services to obtain out-of-network benefits:
    - Qualified provider

- Qualified paraprofessional
- Qualified professional
- Qualified supervising provider
- Qualified therapist
- Qualified intensive-level provider
- Qualified intensive-level professional

What's not covered

1. Services for autism spectrum disorders that are not listed in the definition of "autism spectrum disorder" above.
2. Services for a condition when there is no reasonable expectation that the condition will improve.
3. Services, care or treatment that is not medically necessary.
4. Auditory integration training, chelation therapy, child care fees, cranial sacral therapy, custodial or respite care, hyperbaric oxygen therapy, special diets or supplements for treatment of autism spectrum disorder and animal-based therapy including hippotherapy.
5. Therapy, treatment or services while a covered person is residing in a residential treatment center or receiving inpatient treatment.
6. Travel time for providers of autism spectrum disorder services.

BEHAVIORAL HEALTH – MENTAL HEALTH

Behavioral Health – Mental Health		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Office visits, including evaluations, diagnostic and treatment services	Nothing after deductible	0% coinsurance after deductible
2. Intensive outpatient programs	Nothing after deductible	0% coinsurance after deductible
3. Inpatient services (including residential treatment services) **Please note:** Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.		
a. Room and board	Nothing after deductible	0% coinsurance after deductible
b. Hospital or facility-based professional services	Nothing after deductible	0% coinsurance after deductible
c. Attending psychiatrist services	Nothing after deductible	0% coinsurance after deductible
d. Partial program	Nothing after deductible	0% coinsurance after deductible
4. Transitional treatment services	Nothing after deductible	0% coinsurance after deductible

What's covered

Outpatient mental health services include:

1. Diagnostic evaluations and psychological testing including that for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
2. Psychotherapy and psychiatric services.

3. Mental health intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting.
4. Relationship and family therapy if there is a clinical diagnosis.
5. Treatment of serious or persistent disorders.
6. Treatment of pathological gambling.

Inpatient mental health services include:

1. Room and board.
2. Attending psychiatric services.
3. Hospital or facility-based professional services.
4. Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours.
5. Mental health residential treatment services.
6. Transitional treatment services which includes the following:

   Services for treatment of nervous or mental disorders that are provided to a covered person in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services and shall include the following:

   a. A certified adult mental health day treatment program as defined in DHS 61.75 Wis. Admin. Code, as amended.
   b. A certified child/adolescent mental health day treatment program as defined in DHS 40.04 Wis. Admin. Code, as amended.
   c. A certified community support program as defined in DHS 63.03 Wis. Admin. Code, as amended.
   d. Coordinated emergency mental health services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Services are provided by a program certified by the Department of Health and Family Services under DHS 34.03 and provided in accordance with subch. III of DHS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other providers for stabilization. Certified emergency mental health service plans shall provide timely notice to third party payors to facilitate coordination of services for persons who are experiencing or are in a situation likely to turn into a mental health crisis.

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

why you pay more in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica requires prior authorization (approval in advance) before you receive certain mental health services or treatment. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

To be covered, services must diagnose or treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

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

Your plan's designated mental health and substance abuse provider will coordinate your in-network mental health services. If you require hospitalization, your plan's designated mental health and substance abuse provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance abuse services is not the same.

For a dependent who is a full-time student and is attending a school located in the state of Wisconsin:

> Coverage must be provided by a provider, designated by your plan's designated mental health and substance abuse provider, who is located within the state of Wisconsin and in reasonably close proximity to the school attended by the full-time student dependent for: (a) a clinical assessment of the full-time student dependent's nervous or mental disorders; and (b) if the clinical assessment indicates that the outpatient mental health services are recommended, coverage will be provided for up to five outpatient visits for mental health services as described in this section.
>
> Coverage for mental health services which extend beyond the five outpatient visits will be evaluated and determined by your plan's designated mental health and substance abuse provider. If the full-time student dependent disputes the designated mental health and substance abuse provider's decision for further coverage, he/she may follow the grievance procedure described in **How Do I File a Complaint**.

Coverage for mental health services for the full-time student dependent is subject to all the terms, conditions and limitations of the mental health benefits described in this section.

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

Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. These services must be obtained from a health care professional or facility

that is licensed, certified or otherwise qualified under state law to provide the mental health services and practice independently:

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

What's not covered

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
2. Services, care or treatment that is not medically necessary.
3. Relationship and family therapy in the absence of a clinical diagnosis.
4. Services for telephone psychotherapy, however services that are provided in accordance with Medica's telemedicine policies and procedures may be eligible for coverage under **Telemedicine Health Services** in this plan.
5. Services beyond the initial evaluation to diagnose intellectual or learning disabilities.
6. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received at a halfway house, housing with support, therapeutic group home, boarding school or ranch.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
8. Room and board charges associated with mental health residential treatment services when less than 30 hours a week of mental health services are provided per individual, an on-site medical/psychiatric assessment is not provided within 48 hours of admission and the program has not provided psychiatric follow-up visits at least once per week, or 24-hour nursing coverage.

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Behavioral Health – Substance Abuse		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Office visits, including evaluations, diagnostic and treatment services	Nothing after deductible	0% coinsurance after deductible
2. Intensive outpatient programs	Nothing after deductible	0% coinsurance after deductible
3. Medication-assisted treatment **Note:** When the prescription drug component of this treatment is received at a pharmacy, your prescription drug benefit will be applied.	Nothing after deductible	0% coinsurance after deductible
4. Inpatient services (including residential treatment services)		
a. Room and board	Nothing after deductible	0% coinsurance after deductible
b. Hospital or facility-based professional services	Nothing after deductible	0% coinsurance after deductible
c. Attending physician services	Nothing after deductible	0% coinsurance after deductible
d. Partial program	Nothing after deductible	0% coinsurance after deductible
5. Transitional treatment services	Nothing after deductible	0% coinsurance after deductible

What's covered

Outpatient substance abuse services include:

1. Diagnostic evaluations.
2. Outpatient treatment.

3. Medication-assisted treatment (the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse, and reduce craving in order to sustain recovery).
4. Substance abuse intensive outpatient programs, including day treatment meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting.

Inpatient substance abuse services include:

1. Room and board.
2. Attending physician services.
3. Hospital or facility-based professional services.
4. Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours.
5. Transitional treatment services include the following:

   Services for treatment of alcoholism or other drug abuse problems that are provided to a covered person in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services and shall include the following:

   a. A certified residential treatment program for alcohol and/or drug dependent person as defined in DHS 75.14 Wis. Admin. Code, as amended.
   b. A certified day treatment program for alcoholism and other drug abuse problems as defined in DHS 75.12 Wis. Admin. Code, as amended.
   c. Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine, including but not limited to intensive outpatient programs for narcotic treatment service for opiate addiction as defined in DHS 75.15 Wis. Admin. Code, as amended.

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

What to keep in mind

Medica requires prior authorization (approval in advance) before you receive certain substance abuse services or treatment. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550. Please see **Prior authorization** in

Before You Access Care for more information about prior authorization requirements and processes.

To be covered, services must diagnose or treat substance abuse disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Your plan's designated mental health and substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, your plan's designated mental health and substance abuse provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance abuse services is not the same.

For a dependent who is a full-time student and is attending a school located in the state of Wisconsin:

> Coverage must be provided by a provider, designated by your plan's designated mental health and substance abuse provider, who is located within the state of Wisconsin and in reasonably close proximity to the school attended by the full-time student dependent for: (a) a clinical assessment of the full-time student dependent's alcoholism or other substance abuse problems; and (b) if the clinical assessment indicates that the outpatient substance abuse services are recommended, coverage will be provided for up to five outpatient visits for substance abuse services as described in this section.
>
> Coverage for substance abuse services which extend beyond the five outpatient visits will be evaluated and determined by your plan's designated mental health and substance abuse provider. If the full-time student dependent disputes the designated mental health and substance abuse provider's decision for further coverage, he/she may follow the grievance procedure described in **How Do I File a Complaint**.
>
> Coverage for substance abuse services for the full-time student dependent is subject to all the terms, conditions, and limitations of the substance abuse benefits described in this section.

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

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

- Psychiatrist
- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Substance abuse clinic
- Substance abuse residential treatment center
- Independent clinical social worker
- Marriage and family therapist

- Hospital that provides substance abuse services

What's not covered

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
2. Services, care or treatment that is not medically necessary.
3. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
4. Telephonic substance abuse treatment services, unless such services are provided in accordance with Medica's telemedicine policies and procedures.
5. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide substance abuse services. This includes, but is not limited to, services provided by mental health or substance abuse providers who are not authorized under state law to practice independently, and services received at a halfway house, therapeutic group home, boarding school or ranch.
6. Room and board charges associated with substance abuse treatment services providing less than 30 hours (15 hours for children and adolescents) a week per individual of chemical dependency services, including group and individual counseling, client education and other services specific to chemical dependency rehabilitation.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

CLINICAL TRIALS

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

What's covered

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

What to keep in mind

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

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

What's not covered

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND MEDICAL SUPPLIES

Durable Medical Equipment, Prosthetics and Medical Supplies		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Durable medical equipment and certain related supplies	Nothing after deductible	0% coinsurance after deductible
2. Prosthetics: a. External prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet and hands; ii. Artificial eyes, ears and noses; iii. Breast prostheses b. Repair, replacement or revision of prostheses made necessary by normal wear and use	Nothing after deductible	0% coinsurance after deductible
3. Hearing aids (for covered persons 18 years of age and younger) and cochlear implants for hearing loss that is not correctable by other covered procedures	Nothing after deductible Coverage is limited to one hearing aid per ear every three years.	0% coinsurance after deductible Coverage is limited to one hearing aid per ear every three years.
4. Breast pumps	Nothing. The deductible does not apply.	0% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
5. Medical supplies: a. Injectable pharmaceutical treatments for hemophilia and bleeding disorders b. Total parenteral nutrition c. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and	Nothing after deductible	0% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6.	Eligible ostomy supplies	Nothing after deductible	0% coinsurance after deductible
7.	Insulin pumps and their related supplies	Nothing after deductible	0% coinsurance after deductible

What's covered

Medica covers only a limited selection of durable medical equipment, prosthetics and medical supplies. The repair, replacement or revision of durable medical equipment is covered if it is made necessary by normal wear and use. Hearing aids and certain durable medical equipment, prosthetics and medical supplies must meet specific criteria and some items ordered by your physician, even if they're medically necessary, may not be covered. Medica determines if durable medical equipment will be purchased or rented.

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

What to keep in mind

Medica periodically reviews and modifies the list of eligible durable medical equipment and certain related supplies. To request the most up-to-date list, call Customer Service at one of the telephone numbers listed at the front of this plan. Medica requires prior authorization (approval in advance) before you receive certain durable medical equipment, prosthetics, and/or medical supplies. To determine if Medica requires prior authorization for a particular piece of equipment, prosthetic, or supply, please contact Medica Customer Service at one of the numbers listed at the front of this plan, by logging into mymedica.com or at the number or address listed on the

back of your ID card. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

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

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

In-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a network provider. Hearing aids, when prescribed by a network provider, are covered as described in the table above.

To request a list of durable medical equipment providers and/or hearing aid vendors, call Customer Service at one of the telephone numbers listed at the front of this plan.

Out-of-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a non-network provider.

What's not covered

1. Durable medical equipment, supplies, prosthetics, appliances and hearing aids not on the Medica eligible list.
2. Charges in excess of the Medica standard model of durable medical equipment, prosthetics or hearing aids.
3. Repair, replacement or revision of properly functioning durable medical equipment, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
4. Duplicate durable medical equipment, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.
5. Other disposable supplies and appliances, except as described in this section and **Prescription Drugs**.

EMERGENCY ROOM CARE

Emergency Room Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Services provided in a hospital or facility-based emergency room	Nothing after deductible	Covered as an in-network benefit.
2. Other services received during an emergency room visit (for example x-rays, lab, physician)	Nothing after deductible	Covered as an in-network benefit.

What's covered

Emergency services provided in an emergency room of a hospital, whether network or non-network, from non-network providers will be covered as in-network benefits. In the event you receive such services, you will pay the in-network cost-share associated with the services provided. If you receive any other bill from an emergency room provider, please call Customer Service at one of the telephone numbers listed at the front of this plan.

If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-network benefits until your attending physician agrees it is safe to transfer you to a network facility.

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

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Genetic testing received in an office or outpatient hospital when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing after deductible	0% 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 after deductible	0% coinsurance after deductible

What to keep in mind

Genetic testing is a complex and rapidly changing field. Many genetic tests require prior authorization (approval in advance) or have criteria that must be met for the test to be covered. To determine if Medica requires prior authorization for a particular genetic test, please call Medica Customer Service at one of the numbers listed at the front of this plan. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

- The name of the test;
- The name of the lab performing the test;

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

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

What's not covered

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

HOME HEALTH CARE

Home Health Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Intermittent home health aide services, under the supervision of a registered nurse or social worker c. Skilled physical, speech or occupational therapy when you are homebound d. Home infusion therapy	Nothing after deductible	0% coinsurance after deductible
2. Services received in your home from a physician	Nothing after deductible	0% coinsurance after deductible

What's covered

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

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

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

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

What to keep in mind

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

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

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

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

What's not covered

1. Companion, homemaker and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health club memberships.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** and **Prescription Drugs** in this section.
12. Physical, speech or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.

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

HOSPICE SERVICES

Hospice Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Hospice services	Nothing after deductible	0% coinsurance after deductible

What's covered

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

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

What to keep in mind

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

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

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

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

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

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

1. Be a terminally ill patient; and

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

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

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

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

What's not covered

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

HOSPITAL SERVICES

Hospital Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Outpatient hospital or ambulatory surgical center services	Nothing after deductible	0% coinsurance after deductible
2. Services provided in a hospital observation room	Nothing after deductible	0% coinsurance after deductible
3. Inpatient services For associated physician services, see **Physician and Professional Services** in this section.	Nothing after deductible	0% coinsurance after deductible

What's covered

Hospital and ambulatory surgical center services are covered.

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

What to keep in mind

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

A physician must direct your care.

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

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

What's not covered

1. Drugs received at a hospital on an outpatient basis, except drugs that meet the definition of "professionally administered drugs" or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.
2. Transfers and admissions to network hospitals solely at the convenience of the covered person.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY DIAGNOSIS

Infertility Diagnosis			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Office visits, including any services provided during such visits	Nothing after deductible	0% coinsurance after deductible
2.	Outpatient services received at a hospital	Nothing after deductible	0% coinsurance after deductible

What's covered

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

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

What's not covered

1. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
2. Infertility drugs.
3. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation, and/or storage; and/or any conception that occurs outside the woman's body.
4. Services for intrauterine insemination (IUI).
5. Services for a condition that a physician determines cannot be successfully treated.
6. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
7. Sperm banking and/or storage.

8. Donor sperm.
9. Donor eggs.
10. Services related to adoption.

KIDNEY DISEASE TREATMENT

Kidney Disease Treatment		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Kidney disease treatment, including dialysis	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What's covered

Kidney disease treatment, including dialysis, when received under the direction of a physician is covered.

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

What to keep in mind

See **Transplant Services** for information regarding coverage for kidney transplants and donor-related services.

What's not covered

1. Other services, supplies and associated expenses for the treatment of kidney disease, except as otherwise described as a specific benefit in this plan.

LAB AND PATHOLOGY

Lab and Pathology			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Lab and pathology services received during an office visit	Nothing after deductible	0% coinsurance after deductible
2.	Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	0% coinsurance after deductible
3.	Lab and pathology services received in an inpatient setting	Nothing after deductible	0% coinsurance after deductible

What's covered

Lab and pathology services ordered or prescribed by a physician will be covered as in-network benefits if they are received from a network provider.

What to keep in mind

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

MEDICAL-RELATED DENTAL SERVICES

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Charges for medical facilities and general anesthesia services that are recommended by a physician and received during a dental procedure for a covered person who: a. Is a child under age five; b. Has a chronic disability that: i. is attributable to a mental or physical impairment or combination of mental and physical impairments; ii. is likely to continue indefinitely; and iii. results in substantial functional limitations in self-care, language, learning, mobility, capacity for independent living or economic self-sufficiency; or c. Has a condition that requires hospitalization or general anesthesia for dental care treatment.	Nothing after deductible	0% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
2. For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate	Nothing after deductible	0% coinsurance after deductible
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.	Nothing after deductible	0% coinsurance after deductible
4. Oral surgery for: a. Partially or completely unerupted impacted teeth;	Nothing after deductible	0% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or		
c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth		

What's covered

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

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

What to keep in mind

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

What's not covered

1. Dental services to treat an injury from biting or chewing.
2. Diagnostic casts, diagnostic study models and bite adjustments, unless related to the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder or cleft lip and palate.
3. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
4. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.

5. Any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
6. Any orthodontia, except as described in this section for the treatment of cleft lip and palate.
7. Tooth extractions, except as described in this section.
8. Any dental procedures or treatment related to periodontal disease.
9. Endodontic procedures and treatment, including root canal procedures and treatment, unless provided as accident-related dental services as described in this section.
10. Routine diagnostic and preventive dental services.

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES

Physical, Speech and Occupational Therapies		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Physical therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	0% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	0% coinsurance after deductible
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	0% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	0% coinsurance after deductible
3. Occupational therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	0% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	0% 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.

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

What to keep in mind

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

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

What's not covered

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).
5. Health club memberships.
6. Voice training.
7. Group physical, speech and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that your condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

PHYSICIAN AND PROFESSIONAL SERVICES

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Office visits **Please note:** Some services received during an office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an office visit coinsurance and an outpatient surgical or imaging coinsurance apply.	Nothing after deductible	0% coinsurance after deductible

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
2. Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit coinsurance and outpatient surgical coinsurance apply.	Nothing after deductible	Covered as an in-network benefit.
3. Convenience care		
a. Retail health clinic	Nothing after deductible	0% coinsurance after deductible
b. Virtual care	Nothing after deductible	0% coinsurance after deductible
4. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	Nothing after deductible	0% coinsurance after deductible

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
5. Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
a. Received from a physician during an office visit	Nothing after deductible	0% coinsurance after deductible
b. Received from a physician during an urgent care visit or an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	0% coinsurance after deductible
c. Received from a physician in an inpatient setting	Nothing after deductible	0% coinsurance after deductible
6. Non-surgical services received from a physician in an inpatient setting	Nothing after deductible	0% coinsurance after deductible
7. Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	Nothing after deductible	0% coinsurance after deductible
8. Routine annual eye exams	Nothing. The deductible does not apply.	0% coinsurance after deductible
9. Eyeglass lenses or contact lenses for vision correction limited to $200 of billed charges for in-network and out-of-network combined per covered person every 2 consecutive years. **Please note:** Eyeglass frames are not covered.	Nothing after deductible	Covered as an in-network benefit.

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
10. Allergy shots	Nothing after deductible	0% coinsurance after deductible
11. 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 after deductible	0% coinsurance after deductible
12. Acupuncture Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	Nothing after deductible	0% coinsurance after deductible
13. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing after deductible	0% coinsurance after deductible
14. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	Nothing after deductible	0% coinsurance after deductible

What's covered

In-network benefits apply to:

1. Professional services received from a network provider;
2. Services received from a network nurse practitioner who acts within the scope of his or her license, including but not limited to gynecological services and/or procedures;
3. Emergency services received from network or non-network providers.

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

What to keep in mind

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

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

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

What's not covered

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

PREGNANCY – MATERNITY CARE

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Outpatient prenatal services	Nothing. The deductible does not apply.	0% coinsurance after deductible
2.	Inpatient stay for labor and delivery services – for the mother **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.	Nothing after deductible	0% coinsurance after deductible
3.	Physician services received during an inpatient stay for labor and delivery – for the mother	Nothing after deductible	0% coinsurance after deductible
4.	Inpatient stay – for your newborn **Please note:** Your newborn must be added as a dependent on your plan for this coverage to apply.	Nothing after deductible	0% coinsurance after deductible
5.	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.	Nothing after deductible	0% coinsurance after deductible
6.	Postnatal services	Nothing after deductible	0% coinsurance after deductible

Pregnancy – Maternity Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
7. Home health care visit following delivery	Nothing after deductible	0% coinsurance after deductible

What's covered

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

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

What to keep in mind

Enrolling your baby

Medica does not automatically know of a birth or whether you would like coverage for your baby. To enroll your newborn as a dependent, see **Who's Eligible for Coverage and How Do They Enroll**. Once enrolled, your baby will be covered from birth. For more information, see **Who's Eligible for Coverage and How Do They Enroll**.

Please note: We encourage you to enroll your newborn in your plan within 30 days of the date of birth, date of placement for adoption or date of adoption. For more information, see **Who's Eligible for Coverage and How Do They Enroll**.

Prenatal care

Covered prenatal services include:

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

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

1. Conditions that existed before (and independently of) the pregnancy, such as diabetes or lupus, even if the pregnancy has caused those conditions to require more frequent care or monitoring.

2. Conditions that have arisen during the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or a skin rash.
3. Miscarriage and ectopic pregnancy.

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

Labor and delivery

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

Postnatal care

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

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

For more information about pregnancy care, see the tip sheet at medica.com/membertips.

What's not covered

1. Health care professional services for home labor and delivery.
2. Services from a doula.
3. Childbirth and other educational classes.

PRESCRIPTION DRUGS

Prescription Drugs **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
Your cost if you visit a:		
Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
1. Prescription drugs received at a retail pharmacy, other than those described below or in **Prescription Specialty Drugs**		
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** 0% coinsurance after deductible per prescription unit; or **Preferred brand:** 0% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 0% coinsurance after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit
2. Diabetic equipment and supplies, including blood glucose meters		
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** 0% coinsurance after deductible per prescription unit; or **Preferred brand:** 0% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 0% coinsurance after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit

Prescription Drugs **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
Your cost if you visit a:		
Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
3. Drugs and other supplies (including women's contraceptives), and tobacco cessation products and services that are considered preventive health services		
Generic: Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** 0% coinsurance after deductible per prescription unit; or **Preferred brand:** 0% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 0% coinsurance after deductible per prescription unit	**Generic:** Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Nothing after deductible per prescription unit **Please note:** Tobacco cessation products are not available through a mail order pharmacy.

Your cost if you visit a:	
Network pharmacy:	**Non-network pharmacy:**
4. Orally-administered cancer treatment medications	
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** 0% coinsurance after deductible per prescription unit; or **Preferred brand:** 0% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 0% coinsurance after deductible per prescription unit

What's covered

Prescription drugs and certain over-the-counter (OTC) drugs and supplies are covered if they are:

- Prescribed by an authorized provider;
- Included on Medica's drug list (unless identified as not covered); and
- Received from a pharmacy or a designated mail order pharmacy.

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

What is Medica's Drug List

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

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

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

Generic drugs are your lowest coinsurance option. For your lowest share of the cost, consider a generic covered drug if you and your provider decide it is appropriate for your treatment.

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

Preferred brand drugs have a higher coinsurance. You may consider a preferred brand covered drug to treat your condition if you and your provider decide it is appropriate.

Non-preferred brand drugs have the highest coinsurance. The covered non-preferred brand drugs are usually more costly.

If you have questions about Medica's Drug List or whether a specific drug is covered (and/or whether the drug is generic, preferred brand or non-preferred brand), or if you would like to

request a copy of the Drug List at no charge, call Customer Service at one of the telephone numbers listed at the front of this plan. It is also available on mymedica.com.

What to keep in mind

What is a prescription unit

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

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

One prescription unit from a designated mail order pharmacy is a 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply).

Three prescription units from a pharmacy may be dispensed for covered drugs prescribed to treat chronic conditions. Medica has specifically designated some network pharmacies to dispense multiple prescription units. For the list of these designated pharmacies, visit mymedica.com or call Customer Service.

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

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

- Step therapy (ST)
  Step therapy is a process that involves trying an alternative covered drug first (typically a generic drug) before moving to a preferred brand or non-preferred brand covered drug for treatment of the same medical condition. The medications subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred brand or non-preferred brand drugs.

- Quantity limits (QL)
  Certain covered drugs have limits on the maximum quantity allowed per prescription over a specific period of time. The medications subject to quantity limits are shown on the Drug

List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Exceptions to the Drug List

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

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

If you would like to request a copy of Medica's Drug List exception process or for more information regarding the expedited review process, call Customer Service at one of the telephone numbers listed at the front of this plan.

Mail order pharmacy

Mail order pharmacy benefits apply when covered drugs are received from a designated mail order pharmacy.

To learn more about how to use mail order pharmacy, log in to mymedica.com.

Generic requirement

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

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

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

Additional considerations

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

The list of covered Preventive Drugs and Other Services is specific and limited. For a current list go to mymedica.com and refer to the Preventive Drug and Supply category on the Drug List, or call Customer Service.

Investigational prescription drugs prescribed by a physician for the treatment of an HIV infection or an illness or medical condition arising from or related to an HIV-infection are an exception to the investigative exclusion and the requirement that the drug be listed on Medica's Drug List if such investigational prescription drugs meet the following requirements:

1. Approved by the Food and Drug Administration for the treatment of an HIV infection or HIV-related illness;
2. Is in or has completed a phase three clinical investigation for an HIV-related illness; and
3. Prescribed and administered in accordance with the treatment protocol approved for the drug.

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

What's not covered

1. Drugs and supplies that are not on Medica's Drug List, unless covered through the exception process described in this plan.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (Medica will notify you before enforcement of this provision.)
3. Drugs that have not been approved by the Food and Drug Administration (FDA).
4. Over-the-counter (OTC) drugs not listed on Medica's Drug List.
5. Replacement of a drug due to loss, damage or theft.
6. Sexual dysfunction medications.
7. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
8. Proton pump inhibitors, except for covered persons 12 years of age and younger, and those covered persons who have a feeding tube.
9. Tobacco cessation products or services dispensed through a mail order pharmacy.
10. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
11. Homeopathic medicine.
12. Infertility drugs.
13. Specialty prescription drugs, except as described in **Prescription Specialty Drugs**.
14. Bulk powders, chemicals and products used in prescription drug compounding.

15. Products that are duplicative to, or are in the same class and category as products on Medica's Drug List.
16. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

PRESCRIPTION SPECIALTY DRUGS

Prescription Specialty Drugs		
	Benefits	**You pay:**
1.	Specialty prescription drugs received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit
2.	Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit
3.	Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit

What's covered

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

Specialty prescription drugs are covered if they are:

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

<u>What is Medica's Specialty Drug List</u>

Medica's specialty drug list (Specialty Drug List) is comprised of drugs that meet the medical needs of our covered persons and have been selected based on their safety, effectiveness, uniqueness and cost. They have been approved by the Food and Drug Administration (FDA). A team of physicians and pharmacists meets regularly to review and update the Specialty Drug List.

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

Preferred specialty prescription drugs are your lowest coinsurance option. For your lowest share of the cost, consider a preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

Non-preferred specialty prescription drugs have a higher coinsurance than preferred specialty prescription drugs. Consider a non-preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

If you have questions about Medica's Specialty Drug List or whether a specific specialty prescription drug is covered (and/or the benefit level at which the drug may be covered), or if you would like to request a copy of the Specialty Drug List at no charge, call Customer Service at one of the telephone numbers listed at the front of this plan. It is also available on mymedica.com.

What to keep in mind

These benefits apply when covered specialty prescription drugs are received from a designated specialty pharmacy. A current list of designated specialty pharmacies is available on mymedica.com. You can also call Customer Service at one of the telephone numbers listed at the front of this plan. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

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

<u>What is a prescription unit</u>

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

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

<u>For some prescriptions there are special requirements that must be met in order to receive coverage. These include:</u>

- Prior authorization (PA)
  Certain specialty prescription drugs require prior authorization (approval in advance) from Medica in order to be covered. These medications are shown on the Specialty Drug List with the abbreviation "PA." The Specialty Drug List is available to providers, including designated specialty pharmacies. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes. Your network provider who prescribes the drug should initiate the prior authorization process. You must contact Customer Service to request prior authorization for specialty drugs

prescribed by a non-network provider. You will pay the entire cost of the drug received if you do not meet Medica's authorization criteria.

- Step therapy (ST)
  Step therapy is a process that involves trying an alternative covered specialty prescription drug (typically a preferred drug) before moving to certain other preferred or non-preferred drugs. The medications subject to step therapy are shown on the Specialty Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred or non-preferred drugs.
- Quantity limits (QL)
  Certain covered specialty prescription drugs have limits on the maximum quantity allowed per prescription over a specific period of time. These specialty medications are shown on the Specialty Drug List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Exceptions to the Specialty Drug List

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's Specialty Drug List above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one benefit level.

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

If you would like to request a copy of Medica's Specialty Drug List exception process or for more information regarding the expedited review process, call Customer Service at one of the telephone numbers listed at the front of this plan.

Preferred requirement for specialty prescription drugs

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

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

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

Additional considerations

Investigational specialty prescription drugs prescribed by a physician for the treatment of an HIV infection or an illness or medical condition arising from or related to an HIV-infection are an exception to the investigative exclusion and the requirement that the drug be listed on Medica's Specialty Drug List if such investigational specialty prescription drugs meet the following requirements:

1. Approved by the Food and Drug Administration for the treatment of an HIV infection or HIV-related illness;
2. Is in or has completed a phase three clinical investigation for an HIV-related illness; and
3. Prescribed and administered in accordance with the treatment protocol approved for the drug.

What's not covered

1. Specialty prescription drugs that are not on Medica's Specialty Drug List, unless covered through the exception process described in this plan.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the designated specialty pharmacy. (Medica will notify you before enforcement of this provision.)
3. Specialty drugs that have not been approved by the Food and Drug Administration (FDA).
4. Replacement of a specialty prescription drug due to loss, damage or theft.
5. Specialty prescription drugs prescribed by a provider who is not acting within his/her scope of licensure.
6. Prescription drugs and certain OTC drugs, except as described in **Prescription Drugs** in this plan.
7. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
8. Infertility drugs.
9. Growth hormone, except as specifically described in the benefit table above.
10. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Specialty Drug List.

PREVENTIVE HEALTH CARE

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	0% coinsurance after deductible
2.	Immunizations	Nothing. The deductible does not apply.	0% coinsurance after deductible
3.	Lead poisoning screening for children under six years of age including blood lead tests	Nothing. The deductible does not apply.	0% coinsurance after deductible
4.	Early disease detection services including physicals	Nothing. The deductible does not apply.	No coverage
5.	Routine screening procedures for cancer	Nothing. The deductible does not apply.	0% coinsurance after deductible
6.	Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate) and sterilization	Nothing. The deductible does not apply.	0% coinsurance after deductible
7.	Other preventive health services	Nothing. The deductible does not apply.	0% coinsurance after deductible

What to keep in mind

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

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

- Your plan covers routine mammograms as described above. However, if your doctor recommends additional tests, such as a breast ultrasound or MRI, your x-ray or other imaging benefits will apply. For most plans, that means you'll incur costs for those tests.

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

For more information about preventive care, see the tip sheet at medica.com/membertips.

RECONSTRUCTIVE AND RESTORATIVE SURGERY

Reconstructive and Restorative Surgery		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Reconstructive and restorative surgery	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What's covered

Professional, hospital and ambulatory surgical center services for reconstructive and restorative surgery, including breast reconstruction of the affected tissue incident to a mastectomy are covered. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

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

What to keep in mind

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

After a mastectomy, the plan will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The plan will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

What's not covered

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician and Professional Services** in this section.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
4. Services and procedures primarily for cosmetic purposes.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.
6. Hair transplants.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

SKILLED NURSING FACILITY

Skilled Nursing Facility			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Daily skilled care or daily skilled rehabilitation services, including room and board	Nothing after deductible	0% coinsurance after deductible
2.	Skilled physical, speech or occupational therapy when room and board is not eligible to be covered.	Nothing after deductible	0% coinsurance after deductible
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing after deductible	0% coinsurance after deductible

What's covered

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

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

What to keep in mind

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

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

Skilled nursing facility services are eligible for coverage only if you are admitted to a skilled nursing facility within 30 days after a hospital admission of at least three consecutive days for the same illness or condition.

What's not covered

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health club memberships.
7. Physical, speech or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech and occupational therapy.
10. Long-term care.
11. Charges to hold a bed during a skilled nursing facility absence due to hospitalization or any other reason.

TELEMEDICINE HEALTH SERVICES

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

What to keep in mind

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

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder **Note:** Dental coverage is not provided under this benefit.	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What to keep in mind

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

TRANSPLANT SERVICES

Transplant Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Solid organ and blood and marrow transplant services **Prior authorization is required for all transplant services; this prior authorization must be obtained before the transplant workup is initiated.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage
2. Transportation and lodging reimbursement, as described below, is available for expenses primarily for and essential to the receipt of transplant services. Reimbursement will be for you and a companion or companions whose presence with you is necessary and essential in order for you to receive transplant services, when you receive approved transplant services at a designated facility selected exclusively for medical reasons and you live more than 50 miles from that facility, and will include: a. Transportation for you and one companion (traveling on the same day(s)) to and/or from a designated facility for transplant services for pre-transplant, transplant and post-transplant services. If you are a minor child, transportation expenses for two companions will be reimbursed, provided that the presence of both companions is necessary for you to receive transplant services.		Reimbursement of expenses for out-of-network services is not covered.

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

What's covered

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

What to keep in mind

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

Benefits for each individual 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 benefits apply to transplant services provided by a network provider and received at a designated transplant facility.

A designated transplant facility means a facility that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities. Contact Customer Service to be connected with a Medica case manager for your transplant care.

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

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

What's not covered

1. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.

7. Private collection and storage of umbilical cord blood for directed use.

8. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of “professionally administered drugs.” Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

X-RAYS AND OTHER IMAGING

X-Rays and Other Imaging			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	X-rays and other imaging services received during an office visit	Nothing after deductible	0% coinsurance after deductible
2.	X-rays and other imaging services received during an outpatient hospital or ambulatory surgical center visit **Note:** For these services received during an emergency room visit, see **Emergency Room Care**.	Nothing after deductible	0% coinsurance after deductible
3.	X-rays and other imaging services received in an inpatient setting	Nothing after deductible	0% coinsurance after deductible
4.	MRI, CT and PET CT scans **Note:** Some types of scans may require prior authorization.	Nothing after deductible	0% coinsurance after deductible

What to keep in mind

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

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

What's Not Covered

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

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. The purchase, replacement or repair of eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction and their related fittings, except as specifically described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay**.
5. Services provided by an audiologist when not under the direction of a physician.
6. Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing and their related fittings, except cochlear implants and their related fittings and except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
7. A drug, device or medical treatment or procedure that is investigative.
8. Services or supplies not directly related to your care.
9. Autopsies.
10. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
11. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
12. Physical, occupational or speech therapy or chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
13. Reversal of voluntary sterilization.
14. Personal comfort or convenience items or services.

15. Custodial care, unskilled nursing or unskilled rehabilitation services.
16. Respite or rest care, except as otherwise covered in **Hospice Services** in **What's Covered and How Much Will I Pay**.
17. Travel, transportation or living expenses, except as described in **Transplant Services** in **What's Covered and How Much Will I Pay**.
18. Household equipment, fixtures, home modifications and vehicle modifications.
19. Charges billed by a non-network provider that are not in compliance with generally accepted coding and reimbursement guidelines, including those of the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and the community.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis and amyotrophic lateral sclerosis (ALS).
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability or any similar law.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the conditions of dysplastic nevi and melanoma.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay**.
30. Dental prostheses.
31. 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.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
34. 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).
35. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.

36. 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.
37. Non-medical self-care or self-help training.
38. 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**.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this plan.
42. Orthognathic surgery for cosmetic purposes.
43. Sensory integration, including auditory integration training.
44. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay**.
45. Health care professional services for home labor and delivery.
46. Weight loss or morbid obesity surgery, including initial procedures, surgical revisions and subsequent procedures.
47. Services and supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete and zygote intra-fallopian tube transfer or cryogenic or other preservation techniques used in such or similar procedures.
48. Infertility drugs.
49. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation, and/or storage; and/or any conception that occurs outside the woman's body.
50. Services for intrauterine insemination (IUI).
51. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
52. Sperm banking and/or storage.
53. Donor sperm.
54. Donor eggs.
55. Services related to adoption.

56. Services solely for or related to the treatment of snoring.
57. Interpreter services.
58. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
59. Services for private duty nursing. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the covered person or the covered person's representative and not under the direction of a physician.
60. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
61. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
62. Drugs, supplies and biologics that have not been approved by the U.S. Food and Drug Administration (FDA).
63. New-to-market biologics and professionally administered drugs. Biologics and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Medica.
64. Health club memberships.
65. Long-term care.
66. Treatment to lighten or remove the coloration of a port wine stain.
67. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.
68. Any charges for mailing, interest and delivery, such as the cost for mailing medical records.
69. Animals and any service or treatment related to animals.
70. Charges incurred if you fail to keep a scheduled visit.

What if I Have More Than One Insurance Plan

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

Coordination for Medicare-eligible individuals

The benefits under this plan are not intended to duplicate any benefits to which covered persons are, 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 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 or state law. We will not reduce the benefits due any covered person where federal law requires that we determine our benefits for that covered person without regard to the benefits available under Medicare.

When coordination of benefits applies

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

Definitions that apply to this section

1. A "*plan*" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

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

   b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

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

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

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

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

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

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

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

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

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

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

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

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

Order of benefit determination rules

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

      However, if the other plan does not have the rule described in i. immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
   c. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      i. First, the plan of the parent with custody of the child;
      ii. Then, the plan of the spouse of the parent with the custody of the child; and
      iii. Finally, the plan of the parent not having custody of the child.

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

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

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

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

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

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

Effect on the benefits of this plan

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

2. Reduction in this plan's benefits. The benefits of this plan will be reduced by the benefits that would be payable for the allowable expenses under the other plans, whether or not a claim is made. In no event will this plan pay benefits which, combined with the benefits of the other plans, total more than the allowable expense under this plan.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

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

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

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

Right to Subrogation and Reimbursement

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

1. This plan has a right of subrogation against any third party, individual, corporation, insurer or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. This plan's right of subrogation shall be governed according to this section. This plan's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. This plan's subrogation interest is the reasonable cash value of any benefits received by you.
3. This plan's right to recover its subrogation interest may be subject to an obligation by the plan from any recovery to pay a pro rata share of your disbursements, attorney fees and costs and other expenses incurred in obtaining a recovery from another source unless Medica is separately represented by an attorney. If the plan is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
4. By accepting coverage under the plan, you agree:
    a. That if the plan pays benefits for medical expenses you incur as a result of any act by a third party for which the third party is or may be legally responsible and you later obtain full recovery, you are obligated to reimburse the plan for the benefits paid in accordance with Wisconsin law.
    b. To cooperate with the plan administrator, sponsor or plan or its designee to help protect the plan's legal rights under this subrogation and reimbursement provision and to provide all information the plan may reasonably request to determine its rights under this provision.
    c. To provide prompt written notice to the plan administrator when you make a claim against a party for injuries.
    d. To provide prompt written notice of the plan's subrogation rights to any party against whom you assert a claim for injuries.
    e. To do nothing to decrease or limit the plan's rights under this provision, either before or after receiving benefits, or under the plan.
    f. The plan may take action to preserve its legal rights. This includes bringing suit in your name.

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

h. You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

   i. Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.

   ii. Responding to requests for information about any accident or injuries.

   iii. Making court appearances.

   iv. Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

   v. Complying with the terms of this section.

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

Harmful Use of Medical Services

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

When this applies

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

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

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

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

Medica will send you specific information about:

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

How Do I Submit a Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

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

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

Claims for benefits from non-network providers

Claim forms are provided at medica.com/memberforms. You may also request claim forms by calling Customer Service at one of the telephone numbers listed at the front of this plan. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

You must submit the claim in English along with a Medica claim form to Medica. If you do not provide this information to Medica within 15 months of the date of service, the claim will be denied. Your Medica identification number must be on the claim.

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

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

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

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

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

Claims for services provided outside the United States

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

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

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

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

Time limits

If you have a complaint or disagree with a decision by Medica, you may follow the complaint procedure outlined in **How Do I File a Complaint** or you may initiate legal action at any point.

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

How Do I File a Complaint

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

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

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

Complaint procedures

- If you have a question or are dissatisfied with some aspect of service received from Medica, you can call Customer Service at (952) 945-8000 or 1-800-952-3455. For TTY users, please contact: National Relay Center 711, then ask them to dial Medica at 1-800-952-3455. Customer Service can explain benefit provisions and administrative procedures. They act as an intermediary between you and Medica to resolve your questions, concerns or problems. If that matter cannot be resolved informally to your satisfaction, you have the right to file a formal grievance with Medica.
- Filing a complaint authorizes Medica to review your medical records as needed to resolve your complaint.

Grievance procedures

- If you are dissatisfied with Medica's provision of services, claims practices or administration, you may file a formal grievance.
- To file a grievance, you or anyone else on your behalf, including Customer Service, should write down your concerns and mail or deliver your grievance (in any form) along with copies of any supporting documents to Medica at the following address:

  Medica Customer Service
  Route 0501
  PO Box 9310
  Minneapolis, MN 55440-9310
- Medica will acknowledge your written request for a grievance within five days of receiving it.
- Your grievance and supporting information will be forwarded to a grievance panel. The grievance panel will review the information, testimony or explanation received from you,

Medica staff, providers or other persons to conduct a prompt and thorough investigation. The grievance panel is appointed by Medica and includes a covered person other than the covered person who is filing the grievance, if a covered person is available to serve on the panel.

- At any time during the grievance process, you have the right to appear before the grievance panel to present written or oral information and question those people responsible for making the decision that resulted in the grievance. Medica will notify you in writing of the time and place of the meeting at least seven calendar days in advance.
- Within 30 calendar days of receiving your written request to appear before the grievance panel or for a file review by the grievance panel, Medica will notify you in writing of its decision.
- Filing a grievance authorizes Medica to review your medical records as needed to resolve your grievance.
- If you are not satisfied with Medica's complaint or grievance decision, you may have the right to pursue the optional appeal processes described below.

If your grievance involves a situation that meets the conditions for an expedited grievance, as defined in **Definitions**, you may file an expedited grievance. An expedited grievance may be filed in writing or you may call Medica and work with a Customer Service representative to file a grievance on your behalf. Medica will make a determination within 72 hours of receipt of your request.

Independent review

If you consider a decision by Medica to be partially or wholly adverse to you and the decision involves an adverse determination or experimental treatment determination, or for a rescission of coverage, you or your authorized representative may request a review of Medica's decision by an independent review organization (IRO).

To request an independent review, you must:

1. Complete Medica's grievance process, unless the reason for the review is urgent. (If the reason for the review is urgent, please follow the process described below.)
2. Submit your request for an independent review to Medica within four months of receiving Medica's grievance determination. Please submit your request to:

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

You can bypass Medica's internal grievance procedures if the reason for your independent review request is urgent. You may submit your case as an expedited independent review in the following situations:

1. If you need immediate medical treatment and the time period for completing Medica's grievance process will cause a delay that could jeopardize your life or health, or subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking; or
2. Medica agrees to waive its grievance process. For both regular and expedited reviews, the IRO's adverse or experimental treatment determination decision is binding on both you and Medica.

Filing a complaint with the Office of the Commissioner of Insurance

At any time, you may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by calling 1-800-236-8517 outside of Madison or (608) 266-0103 in Madison to request a complaint form, or you may write to:

Office of the Commissioner of Insurance
Complaints Department
PO Box 7873
Madison, WI 53707-7873

Who's Eligible for Coverage and How Do They Enroll

This section describes who can enroll and how to enroll.

Who can enroll

To be eligible to enroll for coverage you must meet the eligibility requirements of the plan and be an enrollee or dependent as defined in this plan.

How to enroll

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

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

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

Initial enrollment and effective date of coverage

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

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

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

Open enrollment and effective date of coverage

A period communicated by the plan administrator each year during which qualified employees and dependents who are not covered under the plan may elect coverage for the upcoming

calendar year. An application must be submitted to the plan administrator for yourself and any dependents.

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

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

Special enrollment and effective date of coverage

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

1. Loss of other coverage

   a. A special enrollment period will apply to a qualified employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The qualified employee or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

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

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

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

      For purposes of 1.b.:

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

      ii. Loss of eligibility includes:

         - loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
         - cessation of dependent status;

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

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

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

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

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

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

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
- losing coverage as a result of the employer's failure to remit premiums on a timely basis;
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all

benefits and no other COBRA or state continuation coverage is available; or

- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

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

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

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

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

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

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

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the plan; and

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

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

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

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

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

Medical Support Order

The plan is intended to comply with the requirements of applicable law regarding medical support orders. This may result in the delay of a termination of coverage as described in **When Does My Coverage End and What Are My Options for Continuing Coverage**. Notwithstanding any provision of this plan to the contrary, this plan shall recognize support orders that address medical coverage for dependent children and former spouses in accordance as determined by the plan administrator according to its policy relating to the plan established for the purpose of complying with these requirements.

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

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

When your coverage ends

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

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

8. The date of the death of the covered person. In the event of the enrollee's death, coverage for the enrollee's dependents will terminate at the end of the month in which the enrollee's death occurred.
9. For a spouse, the end of the month following the date of divorce or annulment of the marriage.
10. For a dependent child, the end of the month in which the child is no longer eligible as a dependent.
11. For a dependent grandchild, the date the grandchild's parent is no longer eligible as a dependent.
12. For a child placed for adoption where the adoption is not finalized, the date when the child's placement with the enrollee ends.

Continuing your coverage

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

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

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

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

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

1. Your right to continue coverage under state law

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

a. Wisconsin state continuation coverage.

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

b. Notice of rights.

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

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

Enrollee’s loss

The enrollee has the right to continuation of coverage for him or herself and his or her dependents if there is a loss of coverage under the plan because of the enrollee’s voluntary or involuntary termination of employment (for any reason other than gross misconduct) or layoff from employment. In this section, layoff from employment means a reduction in hours to the point where the enrollee is no longer eligible for coverage under the plan.

Enrollee’s spouse's loss

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

a. Death of the enrollee;

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

c. Dissolution of marriage from the enrollee;

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

Enrollee’s child's loss

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

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

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

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

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

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

Responsibility to inform

The enrollee and dependents have the responsibility to inform the plan administrator of a dissolution of marriage or a child losing dependent status under the plan within 60 days of the date of the event or the date on which coverage would be lost because of the event.

Election rights

When the plan administrator is notified that one of these events has happened, the enrollee and the enrollee’s dependents will be notified in writing of the right to continuation coverage within five days after the date the plan administrator receives notice to terminate coverage.

Under Wisconsin law, the enrollee and dependents have 30 days to elect continuation coverage and pay the required contribution to the employer.

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

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

Type of coverage and cost

If continuation coverage is elected, the enrollee’s sponsor is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or employees’ dependents.

Under Wisconsin law, a person continuing coverage may have to make monthly payments to the sponsor or its designee of all or part of the premium for continuation coverage. The amount charged cannot exceed 100 percent of the cost of the coverage.

Duration

Under the circumstances described above, Wisconsin law requires that the enrollee and his or her dependents be allowed to continue coverage as follows:

a. When coverage is lost due to the enrollee's termination of employment for reasons other than misconduct or the enrollee's death, coverage may be continued until the earliest of:

   i. The end of 18 months following the date of termination of employment or the enrollee's death; or

   ii. The date the enrollee or dependent establishes residence outside of the State of Wisconsin; or

   iii. The end of the month for which contributions were made if the enrollee or dependent fails to make timely payment of the required contribution; or

   iv. The date the enrollee or dependent spouse becomes eligible for similar coverage under another group health plan.

b. For instances of annulment of marriage or divorce from the enrollee, coverage of the enrollee's spouse may be continued until the earliest of:

   i. The end of 18 months following the date continuation of coverage began; or

   ii. The date the former spouse establishes residence outside the State of Wisconsin; or

   iii. The end of the month for which contributions were made if the former spouse fails to make timely payment of the required contribution; or

   iv. The date the former spouse becomes eligible for similar coverage under another group health plan; or

   v. The date the enrollee to whom the spouse had been married is no longer eligible for coverage. However, if the enrollee becomes eligible for coverage under a replacement group health plan that provides coverage to the same group, the former spouse shall have the right to coverage under the replacement group health plan.

Extension of benefits for total disability

Coverage will not end automatically for an enrollee or a dependent who is totally disabled on the date the plan is terminated. The plan will temporarily extend the coverage only for treatment of the condition causing the *total disability*. Benefits will be paid until the earlier of the following:

- The date the *total disability* ends.
- The end of a period of 12 months following the date the plan terminated.
- The date the covered person's lifetime maximum amount is paid.

- The end of the current calendar year.

The extension of benefits for total disability will not apply if the succeeding insurer agrees to provide coverage for individuals who were totally disabled on the date the plan is terminated, provided that the succeeding insurer's coverage is not less favorable to the covered person than would have been required by this provision.

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

2. Your right to continue coverage under federal law

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

COBRA continuation coverage

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

General COBRA information

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

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

Qualified beneficiary

For purposes of this section, a qualified beneficiary is defined as:

a. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);

b. A covered spouse of a covered employee; or

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

Enrollee's loss

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

Enrollee's spouse's loss

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

a. Death of the enrollee;

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

c. Divorce or legal separation from the enrollee; or

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

Enrollee's child's loss

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

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

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

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

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

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

Responsibility to inform

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

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator of

that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the plan administrator within 30 days of the determination.

Bankruptcy

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

Election rights

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

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

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

b. The date notice of election rights is received.

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

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

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

Type of coverage and cost

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

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

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

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the plan because of termination of employment or reduction

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

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

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

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

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

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

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

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

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

Trade Act of 2002

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

USERRA continuation coverage

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

General USERRA information

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

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

Employee's loss

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

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

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

Election rights

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

Type of coverage and cost

If the employee elects continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under

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

Duration of USERRA coverage

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

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

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

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

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

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

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

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

COBRA and USERRA coverage are concurrent

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

How Providers are Paid

Network providers

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

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 Medica 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 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.

Applicable law

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

Examination of a covered person

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

Clerical error and misstatements

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

Assignment

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

Plan amendment and termination

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

Enrollee rights

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

Family and Medical Leave Act of 1993 (FMLA)

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

Relationship between parties

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

Discretionary authority

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

Health Savings Accounts (HSA)

This coverage is designed to comply with the requirements of the Internal Revenue Code Section 223 for a federally qualified high-deductible health plan. This coverage may qualify you to make a pre-tax contribution to a health savings account. You are responsible for the cost of all health services, other than preventive care, up to your deductible amount.

For more information about health savings accounts, see the tip sheet at medica.com/membertips.

Definitions

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

Adverse determination. A determination by or on behalf of Medica to which all of the following apply:

1. Medica received and reviewed a request for an admission to or a continued stay at a health care facility or for other care or treatment that is a covered benefit.
2. Based on the information received, Medica determined the requested treatment does not meet Medica's requirements for medical necessity.
3. Medica reduced, denied or terminated the treatment or payment for the treatment.

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 meets the criteria described in subparagraphs 1-3 below:

1. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial; and
2. The subject or purpose of the clinical trial must be the evaluation of an item or service that meets the definition of a benefit and is not otherwise excluded under this plan; and
3. The clinical trial must be described in one of the following subparagraphs:
    a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
    b. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
    c. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

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

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

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

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

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

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

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

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

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

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

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

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

Complaint. Any expression of dissatisfaction that is expressed by a covered person, or a covered person's authorized representative, to Medica, about Medica or its network providers with whom Medica has a direct or indirect contract.

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 benefits under this plan.

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

1. The enrollee's spouse.
2. The following dependent children up to the dependent limiting age of 26:
   a. The enrollee's natural or adopted child;
   b. A child placed for adoption with the enrollee;
   c. A child for whom the enrollee or the enrollee's spouse has been appointed legal guardian; however, upon request by the plan, the enrollee must provide satisfactory proof of dependency;
   d. The enrollee's stepchild;
   e. A child placed as a foster child with the enrollee or the enrollee's spouse; and
   f. The enrollee's or enrollee's spouse's grandchild provided the parent of the grandchild is a covered dependent and less than age 18.

   For residents of a state other than Wisconsin, the dependent limiting age may be higher if required by applicable state law.
3. The enrollee's or enrollee's spouse's adult child over the dependent limiting age of 26 whose education was interrupted by military service. In order to qualify for adult child dependent coverage, an adult child must have been:
   a. Enrolled full-time at a post-secondary school when called to active duty;
   b. Under the age of 27 when called to active duty; and
   c. Currently a full-time student, regardless of age.

   If your dependent adult child meets all the requirements listed above and you want to continue their coverage, contact the plan administrator to request a Return from Military Duty-Student Reinstatement Form.
4. The enrollee's unmarried disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the enrollee for support and maintenance. An illness will not be considered a physical disability. This dependent may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.
5. Coverage as a dependent applies to an adult child who satisfies the following criteria:
   a. The adult child is a full-time student, regardless of age;

b. The adult child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education, and the child is under 27 years of age when called to active duty.

c. The adult child applied to an institution of higher education as a full-time student within 12 months from the date the adult child fulfilled his or her active duty obligation.

Coverage for a student enrolled in school continues during vacation and between consecutive term periods. Coverage will also continue for a student who is on a medically necessary leave of absence and is enrolled in a recognized post-secondary educational institution immediately before the first day of the medically necessary leave of absence. Coverage will continue during a medically necessary leave of absence until the date that is the earlier of (1) one year after the first day of the leave of absence; (2) the date the medically necessary leave of absence terminates; or (3) the date coverage would otherwise terminate under the terms of the plan. Dependents will be required to provide a physician's written certification that the dependent is suffering from a serious illness or injury and that the leave of absence from school is medically necessary.

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

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

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

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

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

1. Any employee included within a unit of employees covered under a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this plan;
2. Any employee who is a nonresident alien and receives no earned income from the sponsor from sources within the United States; and

3. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code.

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

Expedited grievance. A grievance where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the covered person or the ability of the covered person to regain maximum function.
2. In the opinion of the physician with knowledge of the covered person's medical condition, the covered person is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
3. A physician with knowledge of the covered person's medical condition determines that the grievance should be expedited.

Experimental treatment determination. A determination by or on behalf of Medica to which all of the following apply:

1. Medica received and reviewed a request for a proposed treatment.
2. Based on the information provided, Medica determined that the treatment is investigative under the terms of this plan.
3. Medica denied the treatment or payment for the treatment.

The cost or expected cost of the denied treatment exceeds, or would exceed, $250 during the course of the treatment.

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.

Grievance. Any dissatisfaction with the provision of services, claims practices or administration of Medica that is expressed in writing to Medica by, or on behalf of, a covered person.

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. Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

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

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by Medica to be investigative. Medica will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations, and entries in the following drug compendia: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopeia Dispensing Information*.

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

Medical necessity review. Medica’s evaluation of the necessity, appropriateness and efficacy of the use of health care services, procedures and facilities, for the purpose of determining the medical necessity of the service or admission.

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

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

5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

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

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

The network provider directory will be furnished automatically, without charge and it may be obtained by signing in at mymedica.com or by contacting Customer Service.

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

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

1. A percentage of the provider's billed charge; or
2. 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
3. An amount agreed upon between Medica and the non-network provider.

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

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

Out-of-pocket maximum. An accumulation of 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 plan document that will specify the newly applicable time period and may have additional out-of-pocket expenses associated with this change.

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by the plan, or charge in excess of the non-network provider reimbursement amount, or charge you pay in addition to your deductible or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.

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

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

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

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

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

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

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

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

Plan administrator. Dunn County Wisconsin.

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

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

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

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

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

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

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

Qualified employee. An employee of sponsor who is scheduled to work on a regular basis at least twenty (20) hours per week. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

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

Reconstructive. Surgery to rebuild or correct a:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sponsor. Dunn County Wisconsin.

Telemedicine. Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An originating site includes a health care facility at which a patient is located at the time the services are provided by means of telemedicine. A distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services.

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

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

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

Virtual care. Professional evaluation and medical management services provided to patients, in locations such as their home or office, through email, telephone or webcam. Virtual care is used to address non-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. In accordance with applicable state and federal laws, the period of time that must pass before an otherwise qualified employee and/or dependent is eligible to become covered under the plan (as determined by the sponsor's eligibility requirements). However, if a qualified employee or dependent enrolls through a special enrollment period as set forth in **Who's Eligible for Coverage and How Do They Enroll**, any period before such 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 County Manager of the sponsor has executed the foregoing plan on behalf of sponsor on this 24th day of January, 2020.

By: Paul R. Miller
(please print)

(signature on file)
(signature)

Its: County Manager