Medica Health Plans

www.medica.com

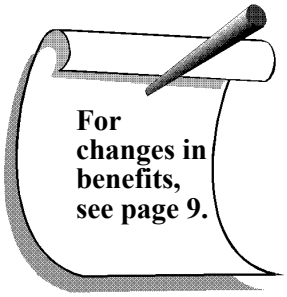
MEDICA®

2009

A Health Maintenance Organization with Out-of-Network Benefits

Serving: Most of Minnesota

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



Medica has been awarded "Excellent" Accreditation for its commercial HMO/POS plans from the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

Enrollment code for this Plan:

M21 High Option- Self Only
M22 High Option- Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-853

Important Notice from Medica Health Plans About
Our Prescription Drug Coverage and Medicare

OPM has determined that the Medica Health Plans prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription coverage that's, at least as good as Medicare's prescription coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of **Medica Health Plans** under our contract (CS2916) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Medica Health Plans administrative office is:

Medica Health Plans
401 Carlson Parkway
Minnetonka, MN. 55305

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2009 and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means the Medica Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health plan benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-952-3455 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask your pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We encourage you to see physicians, hospitals, and other providers that contract with us to receive your best level of coverage. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We offer enrollment in a Medica Health Plans.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Open Access Plan

Medica Health Plans offers open access to a robust network of physicians, hospitals and other providers throughout the Medica service area. Although a long-term relationship with a primary physician is encouraged, the selection of a primary care provider is not required under this Plan. You or your family member may seek services from any network provider without a referral. You may also see Non-Network providers for most services in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota, but will receive your best level of benefits through network providers.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Out-of-Network benefits

Our HMO offers out-of-network benefits in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket-costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your calendar year deductible, copayments or coinsurance.

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

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 member or per service with targeted outcome.

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

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

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

Non-Network providers

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

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Medica Health Plans was established in 1991
- Medica Health Plans is a not for profit company servicing Minnesota for over three decades.

If you want more information about us, call 1-800-952-3455 or write to Medica Health Plans, Customer Service, CP 5555, PO Box 9310, Minneapolis, MN. 55440-9310.

Member Bill of Rights

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

1. Available and accessible services, including emergency services (defined in this brochure) 24 hours a day, seven days a week;

2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care;

3. Participate with providers in decision making regarding your health care, including the right to refuse treatment recommended to you by Medica Health Plans or any provider;

4. Be treated with respect and recognition of your dignity and privacy; including privacy of your medical and financial records maintained by Medica Health Plans or any network provider in accordance with existing law;

5. Receive information about Medica Health Plans, its services, its practitioners and providers, and members' rights and responsibilities;

6. Appeal a decision regarding your health care coverage by calling Customer Service at the telephone numbers listed in this brochure;

7. Make recommendations regarding Medica Health Plan's members' rights and responsibilities statement.

Member Responsibilities

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

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care;

2. Providing the necessary information to health care professionals or Medica Health Plans needed to determine the appropriate care. This objective is best obtained when you share:

a. Information about lifestyle practices; and

b. Personal and family health history;

3. Understanding your health problems and agreeing to, and following, the plans and instructions for care given by those providing health care;

4. Practicing self-care by knowing:

a. How to recognize common health problems and what to do when they occur;

b. When and where to seek appropriate help; and

c. How to prevent health problems from recurring;

5. Practicing preventive health care by:

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

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

If you want more information about us, call 1-800-952-3455, or write to Medica Health Plans, Customer Service, CP 5555, PO Box 9310, Minneapolis, MN. 55440-9310. You may visit our Web site at www.medica.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians and dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Minnesota Service Area. This is where our providers practice. Our service area in **Minnesota** is: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, Mcleod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Roseau, Scott, Sherburne, Sibley, St Louis, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena Waseca, Washington, Watonwan, Wilkin, Winona, Wright, and Yellow Medicine counties.

Additional network access is available in adjoining communities in **Wisconsin, South Dakota** and **North Dakota.** However, you are not eligible to enroll in this plan if you live or work in these adjoining communities.

Ordinarily, you must get your care from providers who contract with us. We do offer coverage for services from Non-Network providers in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota. The benefit level for services from Non-Network providers will be determined based upon medical necessity and services rendered in accordance with this brochure.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to Medica Health Plans High Option Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 80.
- Added In-Network coverage for hearing aids for members 19 yrs of age and older. See page 27.
- Added In-Network and Out-of-Network coverage for Amino Acid-based Elemental Oral Formulas. See page 25.
- Limited the Out-of-Network Organ and Bone Marrow Transplant services to plan limit of $100,000 per member per calendar year. See pages 35 - 39.
- Discontinued coverage for drugs provided or administered by a physician unless intravenous infusion or injection, intramuscular injection or intraocular injection is needed. See page 21.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-952-3455 or write to us at Customer Service, CP555, PO Box 9310, Minneapolis, MN., 55440-9310.

Where you get covered care

You get care for "Plan providers" and "Plan facilities". You will only pay copayments, deductibles, and/or coinsurance. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. You can also get care from Non-Network providers in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site www.medica.com.

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

Other Covered Professionals: Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and those of Medica Health Plans. These professionals include, but are not limited to:

- Audiologists
- Chiropractors
- Clinical Psychologists
- Clinical Social Workers
- Independent Labs
- Nurse Practitioners
- Physical, Speech, and Occupational Therapists
- Physician Assistants

In certain situations, you have a right to continuity of care. If you are a new member as a result of changing health plans and your current provider is not a network provider, you may be eligible to continue care with that provider at the in-network benefit level. Please contact Customer Service at 1-800-952-3455. for additional information.

Surgery for Weight Loss

Services must be provided under the direction of a designated physician and received at a designated facility. Surgery for morbid obesity must be provided by a designated network physician and received at a designated network facility. A designated physician or facility is a network physician or hospital that has been designated by the American Society of Bariatric Surgeons or Medica Health Plans to provide surgery for morbid obesity.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. This list is also on our Web site, www.medica.com.

Organ and Bone Marrow Transplants

Medica Health Plans has entered into separate contracts to provide certain transplant-related health services to members receiving transplants.

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

Medica Health Plans requires that all pre-transplant, transplant and post-transplant services, from the time of the initial evaluation through no more than one year after the date of the transplant, be received at one designated facility (that you select from among the list of transplant facilities Medica Health Plan provides).

What you must do to get covered care

Any time you or a member of your family needs care, you may chose to see any provider in the network. When you seek care from a provider who is not in the health plan network, your care will not be eligible for In-Network benefits, but may be considered under your Out-of-Network benefits, in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota.

- **Primary care**

Your primary care physician can be a Family Practitioner, Internist, Ob/Gyn, Pediatrician or General Practitioner. Your primary physician will provide most of your health care or suggest that you see a specialist. You can see any specialist in the network without a referral.

If you want to change your primary care physician or if your primary care physician leaves the Plan, we will help you select a new one. Please call Customer Service at 1-800-952-3455 or visit www.medica.com.

- **Specialty care**

You have direct access to all specialists in the Medica Health Plans network- no referrals are required. We recommend working with your primary care physician who can guide you to specialists as needed. Certain specialties may require a doctor's order or previous medical assessment in order to access specialty care- your primary care physician can assist you in this area.

Here are some things you should know about specialty care:

- If you need to see a specialist frequently because of chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits, without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you should receive treatment from a specialist who does.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else. You may also contact Customer Service at 1-800- 952-3455 for assistance or visit www.medica.com.

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - Reduce our service area and you enroll in another FEHB Plan

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Customer Service immediately at 1-800-952-3455. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

- **Your hospital stay**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. No precertification is required.

- **How to precertify an admission**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. No precertification is required.

- **Maternity care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. No precertification is required.

- **What happens when you do not follow the precertification rules when using non-network facilities**

No precertification is required.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necssary care.

Services requiring our prior approval

You must obtain prior approval for certain services or supplies. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior approval. Medica Health Plans uses written procedures and criteria when reviewing your request for prior approval. To request prior approval for a service or supply, either you, someone on your behalf or your Plan physician must call Medica Health Plans at 1-800-952-3455.

Your physician must obtain prior approval for:

- Home Health Care
- Bone Growth Stimulators
- Breast Implant Removal, Revision or Reimplantation
- Cancer Clinical Trial Participation
  Coverage of Routine Supplies & Services (for out-of-network providers)
- Computed Tomography (CT) - for Coronary Artery Calcium Scoring (CACS) including Electron Beam (EBCT), Helical, Multi-detector (MDCT) and Multi-row (MRCT)
- Computed Tomography (CT) Coronary Angiography for Detection or Assessment of Coronary Artery Disease
- Extended Hours Home Care (Skilled Nursing Services) for Patients with Medically Complex or Medically Fragile Conditions
- Female Breast Reduction Surgery Reduction Mammoplasty
- Gastrointestinal Surgery for Morbid Obesity
- Investigational procedures/Services/New technology/Care Management Policy and Humanitarian Device Exemptions (HDEs)
- Nasal Reconstructive Surgery - Rhinoplasty Procedure with or without Septoplasty
- Out-of-Network referrals by In-Network providers
- Outpatient Enteral Nutrition Therapy
- Abdominoplasty/Panniculectomy
- Personal Care Assistant (PCA)
- Sclerotherapy for Varicose Veins of the Leg
- Skilled Nursing Facility
- Organ and Marrow Transplants (excluding cornea)
- Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome
- Real Time Glucose Monitor
- Inpatient Mental Health and Substance Abuse
- Growth Hormone Therapy
- Reconstructive Surgery

When you, someone on your behalf or your primary care physician calls, the following information may be required:

- Name and telephone number of the provider who is making the request;
- Name, telephone number, address and type of specialty of the provider to whom you are being referred, if applicable;
- Services being requested and the date those services are to be rendered (if scheduled);

- Specific information related to your condition (for example, a letter of medical necessity from your provider);
- Other applicable member information (i.e., member ID number).

Medica Health Plans will review your request and provide a response to you and your primary care physician within 10 business days after the date your request was received, provided all information reasonably necessary to make a decision has been made available to Medica Health Plans.

Medica Health Plans will inform both you and your primary care physician of the decision within 72 hours from the time of the initial request if your primary care physician believes that an expedited review is warranted, or Medica Health Plans concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

If Medica Health Plans does not approve your request for prior approval, you have the right to appeal the decision. Please see Section 8. *The disputed claims process* for more information about these rights.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay an in-network copayment of $15 per office visit; and when you go in the hospital, you pay a $300 copayment per in-network admission to the hospital.

Cost-Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, copayment, coinsurance) for the covered care you receive.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay a 20% coinsurance for infertility services or durable medical equipment.

Deductible

A deductible is the fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

In- Network Deductible

The calendar year deductible is $250 per person. Under family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500.

Out-of-Network Deductible

The calendar year deductible is $500 per person. Under family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000.

Difference between our Plan allowance and the bill

If the amount billed by the Non-Network provider is greater than the Non-Network provider reimbursement amount, *you must pay the difference*. Such difference is in addition to any copayment, coinsurance or deductible amount you may be responsible for according to the terms described in this brochure. In addition, such difference will not be applied to the out-of-pocket maximum.

The amount that Medica Insurance Company (MIC) will pay on behalf of Medica Health Plans to a Non-Network provider for each benefit is equal to the lesser of the:

- Provider's charge; or
- Amount MIC determines, based on prevailing reimbursement rates or marketplace charges, for similar services and supplies, in the geographic area in which the benefit is provided; or
- Amount agreed upon between MIC and the non-network provider.

Your catastrophic protection out-of-pocket maximums

In-Network Out-of-Pocket Maximums

After your deductible, copayments and coinsurance total of $3,000 per person or $5,000 per family in any calendar year, you do not have to pay any more for In-Network covered services.

Be sure to keep accurate records of your deductible, copayments and coinsurance since you are responsible for informing us when you reach the maximums.

Out-of-NetworkOut of Pocket Maximums

After your deductible, copayments and coinsurance total of $5,000 per person in any calendar year, you do not have to pay any more for Out-of-Network covered services.

Charges in excess of the non-network provider allowance amount do not accummulate to the catastrophic out-of-network maximum amount.

Be sure to keep accurate records of your deductible, copayments and coinsurance since you are responsible for informing us when you reach the maximums.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. Benefits

See page 9 for how our benefits changed this year. Page 77 and 78 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Medica Health Plans Overview

This Plan offers a High Option with Out-of-Network benefits. Our benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 1-800-952-3455 or at our Web site at www.medica.com.

Our High Option offers the following unique features:

- Medica Health Plans service area includes most of the Minnesota counties, plus adjoining communities in Wisconsin, South Dakota and North Dakota. However, to enroll in this plan, you must live or work in the Minnesota service area. If you live or work in Wisconsin, South Dakota or North Dakota, you are not eligible to enroll in this plan.
- No primary care physician designation required.
- In-Network and Out-of Network benefits available for most services in Minnesota and adjoining communities in Wisconsin, South Dakota and North Dakota.
- Additional Special Features unique to Medica Health Plans

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians provide or arrange your care.
- A facility coinsurance applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits and $500 per person ($1,000 per family) for Out-of Network benefits. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- In addition to any applicable deductible and copayment or coinsurance described for Out-of-Network benefits, you will be responsible for any charges in excess of the Non-Network provider allowance amount.

YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME SERVICES AND SUPPLIES. Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • Office visits in a physician's office (including office visits for Organ and Tissue Transplants, Surgery for Weight Loss, Reconstructive Surgery and TMJ) • In an urgent care center • Office medical consultation • Second surgical opinion	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Professional services of physicians • During a hospital stay • In a skilled nursing facility	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Professional services of physicians • House call	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered:	*All charges*

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services (cont.)	
• *Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in Section 5(f) Prescription drug benefits.*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • Non-routine mammograms	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Tests, such as: • X-rays • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Preventive care, adult	
Routine physical once per calendar year which includes: Routine screenings, such as: • Total Blood Cholesterol	**In-Network: no deductible** Nothing **Out-of-Network:** No coverage
• Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening - Double contrast barium enema - Colonoscopy screening	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Routine Prostate Specific Antigen (PSA) test once per calendar year	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see *Diagnostic and treatment services,* above.	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Routine mammogram once per calendar	**In-Network: no deductible**

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	
	Nothing **Out-of-Network:** 40% of the Plan allowance
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Physical exams and immunizations required for employment, insurance, licensure, judicial or administrative proceedings or as otherwise covered under this plan.*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
• Well-child care charges for routine examinations, immunizations and care • Examinations, such as: - Eye exams to determine the need for vision correction - Hearing exams to determine the need for hearing correction - Examinations done on the day of immunizations	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Physical exams and immunizations required for employment, insurance, licensure, judicial or administrative proceedings or as otherwise covered under this plan.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Postnatal care	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
Delivery	See Hospital benefits (Section 5 (c)) and Surgery benefits (Section 5 (b))
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	
Family planning	
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) Note: We cover oral contraceptives and diaphragms under the prescription drug benefit.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
• Voluntary sterilization (See Surgical procedures Section 5 (b))	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	
• *Services for genetic screening and testing except when:* - *Recommended by a genetic counselor as predictive of a disease process, and treatment standards of care exist for the disease process; or* - *Reproductive choices would be made based on the test findings.*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • Cost of donor egg • *Services related to surrogate pregnancy for a person not covered as a member under this Plan.* • *Sperm banking* • *Adoption* • *Embryo and egg storage*	*All charges*
Allergy care	
• Allergy injections	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
• Testing and treatment	**In-Network:no deductible** $15 per office visit

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Allergy care (cont.)	
	Out-of-Network: 40% of the Plan allowance
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 35 through 40.	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
• Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Amino acid-based elemental oral formulas limited to 5 years & younger Note: Growth hormone is covered under the specialty prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered : • *Enteral feedings (unless they are the sole source of nutrition) except for the dietary medical treatment of PKU.* • *Nutritional and electrolyte substances except as noted above.* • *Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
We cover services of each of the following: • Physical therapists and • Ooccupational therapists Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Exercise programs* • *Services primarily educational in nature* • *Vocational and job rehabilitation* • *Recreational therapy* • *Self-care and self-help training (non-medical)* • *Health clubs* • *Outpatient rehabilitation services when no medical diagnosis is present.* • *Physical or occupational therapy when there is no reasonable expectation that the condition will improve over a predictable period of time according to generally accepted standards in the medical community.*	*All charges*
Speech therapy	
We cover services up to 60 combined visits per calendar year for the following: • Speech therapist	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Voice training and voice therapy*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing	**In-Network: no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance
• Hearing aids for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures. Limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	**In-Network:** 20% **Out-of-Network:** No Coverage

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment, and supplies) (cont.)	
• Hearing aids for members 19 years of age and older for hearing loss that is not correctable by other covered procedures Limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider. Note: Medica Health Plans pays up to $2,500 per unit every three years.	**In-Network:** 20% **Out-of-Network:** No Coverage
Not covered: • *Services provided by an audiologist when not under the direction of a physician.* • *Hearing aids not on the Medica Health Plans eligible list. Please contact Medica Health Plans Customer Service at 1-800-952-3455 or visit* www.medica.com.	*All charges*
Vision services (testing, treatment, and supplies)	
• Refractive eye exams once per calendar year Note: See *Preventive care, children* for eye exams for children.	**In-Network: no deductible** Nothing **Out-of-Network:** No Coverage
• One pair of eyeglass lenses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts).	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
• 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. Note: 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.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *The purchase, replacement or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings.* • *Eye exercises and orthoptics except as noted above* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Orthopedic and corrective shoes unless therapeutic shoes for persons with diabetes* • *Arch supports unless custom made and transferable* • *Foot orthotics unless custom made and transferable* • *Heel pads and heel cups* • *Lumbosacral supports* • *Elastic stockings (unless custiom made), support hose, and other supportive devices*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• *Prosthetic replacements not made necessary by normal wear and use.*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. A definition of durable medical equipment is included in Section 10. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps • TMJ splints and adjustments • Power Mobility Devices (i.e. scooters, power wheel chairs)- when medical necessity criteria is met Note: See *Hearing services (testing, treatment and supplies)* for hearing aid coverage Note: Call us at 1-800-952-3455 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Some equipment may require prior approval.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
• Scalp hair prostheses due to alopecia areata Note: Medica Health Plans pays up to $350 **per benefit level**. This is calculated each calendar year.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Durable medical equipment and supplies, prosthetics and appliances not medically necessary or not otherwise eligible under this brochure.* • *Items or supplies primarily used for luxury purposes such as whirlpools, water purifiers and other such items.* • *Charges in excess of the Medica Health Plans standard model of durable medical equipment, prosthetics or hearing aids.*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
• *Repair, replacement or revision of durable medical equipment, prosthetics and hearing aids, except when made necessary by normal wear and use.* • *Duplicate durable medical equipment, prosthetics and hearing aids.* • *Personal comfort or convenience items or services, including but not limited to breast pumps except when the pump is medically necessary.* • *Household equipment, fixtures, home modifications and vehicle modifications.*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Skilled physical, speech or occupational therapy when you are homebound. • Home infusion therapy • You pay nothing for Home Health Care services for high-risk prenatal care services. Home Health Care services are subject to prior approval- please contact Customer Service at 1-800-952-3455 for assistance. Note: Your place of residence is where you make your home. This may be your own dwelling, a relative's home, an apartment complex that provides assisted living services or some other type of institution. However, an institution will not be considered your home if it is a hospital or skilled nursing facility.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Companion, homemaker and personal care services* • *Services provided by a member of your family.* • *Custodial care and other nonskilled services* • *Vocational and job rehabilitation* • *Recreational therapy*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
• *Disposable supplies and appliances, except as described in this brochure.*	*All charges*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy. Note: Coverage is limited to 15 visits per calendar year on Out-of Network benefits. This limit applies whether or not the deductible has been met.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Hypnotherapy*	*All Charges*
Alternative treatments	
• Acupuncture • Naturopathic services • Biofeedback Note: Services must be administered or under the supervision of a eligible provider for coverage.	**In-Network: no deductible** $15 per office visit **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Alternative treatments not administered or under the supervision of an eligible provider.*	*All charges*
Educational classes and programs	
Coverage is limited to: • Healthy Pregnancy Program • Treatmemt Decision Support • Smoking Cessation Programs	*See Special Features(Section 5 (h))*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits and $500 per person ($1,000 per family) for Out-of Network benefits. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- In addition to any applicable deductible and copayment or coinsurance described for Out-of-Network benefits, you will be responsible for any charges in excess of the Non-Network provider allowance amount.
- Medica Health Plans has entered into separate contracts to provide certain organ and transplant-related health services to members receiving transplants. Please refer to Section 3 *How you get care for* additional information.

YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES. Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval and identify which surgeries require prior approval. No precertification is required.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Maternity delivery • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery)	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
• Insertion of internal prosthetic devices. See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Treatment of TMJ Some surgical services may be subject to prior approval. Please see Section 3 for a list of procedures. You may contact Customer Service at 1-800-952-3455 for additional assistance. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Surgery for Weight Loss Benefits apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or facility is a network physician or hospital that has been designated by the American Society of Bariatric Surgeons or Medica Health Plans to provide surgery for morbid obesity. You may contact Customer Service at 1-800-952-3455 for a list of designated physicians and facilities.	**In-Network:** 20% **Out-of-Network:** No Coverage
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Supplies and services for surgery for morbid obesity not authorized by Medica Health Plans.* • *Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature not otherwise covered under this Plan.* • *Services and procedures primarily for cosmetic purposes.* • *Treatment for spider veins*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery	
• Surgery to correct a functional defect. • Surgery to correct a condition caused by injury or illness if: - the condition produced an effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Reconstructive Surgery is subject to prior approval. Please see Section 3 for a list of procedures. You may contact Customer Service at 1-800-952-3455 for additional assistance. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to gender re-assignment.* • *Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in this brochure.* • *Repair of a pierced body part and surgical repair of bald spots or loss of hair.*	*All Charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• *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.* • *Services and procedures primarily for cosmetic purposes.* • *Surgical correction of male breast enlargement primarily for cosmetic purposes.* • *Hair transplants*	*All Charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Oral surgery for partially or completely unerupted impacted teeth, a tooth root without extraction of the entire tooth (this does not include root canal therapy), or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and • Excision of cysts and incision of abscesses when done as independent procedures. • Other surgical procedures that do not involve the teeth or their supporting structures.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Oral implants and transplants except as related to surgery for cleft lip and cleft palate.* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Section 3* for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Single, double or lobar lung	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myleogenous leukemia - Hemoglobinopathy (i.e. Franconi's Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- De-novo myelomo Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance**.**	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance**.**	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered services: Subject to medical necessity	**In-Network:** 20%

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance**.**	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Tandem transplants for covered transplants: Subject to medical necessity Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance**.**	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for: • Allogeneic transplants for - Chronic lymphocytic leukemia - Chronic lympphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/ myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Breast cancer - Epithelial ovarian cancer - Small cell lung cancer • Autologous transplants for the following autoimmune diseases - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma-SSc (severe, progressive) • National Transplant Program (NTP) Transplant services are subject to prior approval-please contact Customer Service at 1-800-952-3455 for assistance. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance Note: Out-of-Network organ/tissue transplant services limited to $100,000 per transplant per calendar year.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor.* • *Implants of artificial organs* • *Transplants not listed as covered.*	*All Charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• *Supplies and services related to transplants that would not be authorized by Medica Health Plans under the medical criteria referenced in this section.* • *Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow that relates to transplants that would not be authorized under Medica Health Plans' medical criteria.* • *Living donor transplants that would not be authorized by Medica Health Plans under the medical criteria referenced in this section.* • *Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.* • *Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature otherwise not covered under the Contract.* • *Transplants and related services that are investigative.* • *Private collection and storage of umbilical cord blood for directed use.* • *Travel, transportation or living expenses*	*All Charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits and $500 per person ($1,000 per family) for Out-of Network benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- In addition to any applicable deductible and copayment or coinsurance described for Out-of-Network benefits, you will be responsible for any charges in excess of the Non-Network provider allowance amount.

YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • Semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. A private room is covered only for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	**In-Network:** $300 per hospital or facility admission (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines while admitted • Diagnostic laboratory tests and X-rays • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Physician services, including anesthesia, billed by the hospital	**In-Network:** $300 per hospital or facility admission (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. • Take home items	**In-Network:** $300 per hospital or facility admission (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic X-rays, and imaging services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Laboratory tests and pathology services	**In- Network:no deductible** Nothing **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
Extended care/Skilled nursing care benefit: Services are covered only after transfer to an extended care/skilled nursing facility within 30 calendar days of discharge from a hospital in which you were confined for not less than three consecutive calendar days.	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Not covered: • *Custodial care and other non-skilled services* • *Self-care or self-help training (non-medical)* • *Private room, except for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation.* • *Services primarily educational in nature.* • *Vocational and job rehabilitation* • *Recreational therapy* • *Voice training and voice therapy* • *Outpatient rehabilitation services when no medical diagnosis is present.*	*All Charges*
Hospice care	
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. A designated hospice program means a hospice program that has entered into a separate contract with Medica to provide hospice services to members. The specific services you receive may vary depending upon which program you select. Respite care is a form of hospice services that gives uncompensated primary caregivers (i.e., family members or friends) rest or relief when necessary to maintain a terminally ill member at home. Respite care is limited to not more than five consecutive days at a time. A plan of care must be established and communicated by the designated hospice program staff to Medica Health Plans. To be eligible for coverage, hospice services must be consistent with the designated hospice program's plan of care.	**In- Network:no deductible** Nothing **Out-of-Network:** No Coverage

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
To be eligible for the hospice benefits you must: • Be a terminally ill patient; and • Have chosen a palliative treatment focus (i.e., one that emphasizes comfort and supportive services rather than treatment attempting to cure the disease or condition). You will be considered terminally ill if there is a written medical prognosis by your physician that your life expectancy is six months or less if the terminal illness runs its normal course. This certification must be made not later than two days after the hospice care is initiated. Members who elect to receive hospice services do so in place of curative treatment for their terminal illness for the period they are enrolled in the hospice program. You may withdraw from the hospice program at any time upon written notice to the designated hospice program. You must follow the designated hospice program's requirements to withdraw from the designated hospice program.	**In- Network:no deductible** Nothing **Out-of-Network:** No Coverage
Not covered: • *Respite care for more than five consecutive days at a time.* • *Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.* • *Services not included in the designated hospice program's plan of care.* • *Services not provided by the designated hospice program.* • *Hospice daycare, except when recommended and provided by the designated hospice program.* • *Any services provided by a family member or friend, or individuals who are residents in your home.* • *Financial or legal counseling services, except when recommended and provided by the designated hospice program.* • *Housekeeping or meal services in your home, except when recommended and provided by the designated hospice program.* • *Bereavement counseling, except when recommended and provided by the designated hospice program.*	*All Charges*

Benefit Description	You pay
Ambulance	
• Ambulance services or ambulance transportation (ground or air) to the nearest hospital for an emergency	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of-Network:** 20% of the Plan allowance (In-Network calendar year deductible applies)
Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: • Transportation from hospital to hospital when - Care for your condition is not available at the hospital where you were first admitted; or - Required by Medica Health Plans • Transportation from hospital to skilled nursing facility	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of-Network:** 40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Not Covered: • *Ambulance transportation to another hospital except when authorized by Medica.* • *Non-emergency ambulance transportation services (except as described in this section).*	*All Charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits.
- Services for Out-of-Network emergencies and accidents are covered under In-Network benefits. The In-Network deductible is applicable to these services.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

In life threatening emergencies, contact the local emergency system (e.g. 911 telephone system) or go to the nearest hospital emergency room. In other situations, go to the nearest Urgent Care provider, contact your primary care physician's office or call Medica CallLink Nurse Line at 1-800-962-9497 (hearing impaired individuals should call 1-800-855-2880). Medica CallLink Nurse Line is available 24 hours a day to assist.

Emergencies outside our service area

In life threatening emergencies, contact the local emergency system (e.g. 911 telephone system) or go to the nearest hospital emergency room. In other situations, go to the nearest Urgent Care provider, contact your primary care physician's office or call Medica CallLink Nurse Line at 1-800-962-9497 (hearing impaired individuals should call 1-800-855-2880). Medica CallLink Nurse Line is available 24 hours a day to assist.

You must notify Medica Health Plans of emergency inpatient services as soon as reasonably possible after receiving inpatient services. Call Customer Service at 1-800-952-3455.

For emergency mental health or substance abuse inpatient services, you must notify Medica Health Plans designated mental health and substance abuse provider as soon as reasonably possible at :

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

If you are confined in a Non-Network facility as a result of an emergency, your coverage under this benefit continues until your attending physician agrees it is safe to transfer you to a network facility.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center Note: We waive the ER copay if you are admitted to the hospital.	**In-Network:no deductible** $15 per office visit **Out-of Network:** 20% of the Plan allowance (In-Network calendar year deductible applies)
• Emergency care at a hospital Emergency Room	**In-Network:no deductible** $75 per office visit **Out-of Network:** 20% of the Plan allowance (In-Network calendar year deductible applies)
Not covered: • *Transfers and admissions to network hospitals solely at the convenience of the member.*	*All Charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care at a hospital Emergency Room	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of Network:** 20% of the Plan allowance (In-Network calendar year deductible applies)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Unauthorized continued inpatient services in a non-network facility once the attending physician agrees it is safe to transfer you to a network facility.*	*All Charges*

Benefit Description	You pay After the calendar year deductible…
Ambulance	
• Ambulance services or ambulance transportation (ground or air) to the nearest hospital for an emergency Note: See *Ambulance* under Section 5(c) for non-emergency service.	**In-Network:** 20% (In-Network calendar year deductible applies) **Out-of-Network:** 20% of the Plan allowance (In-Network calendar year deductible applies)
Not covered: • *Ambulance transportation to another hospital except when authorized by Medica.*	*All Charges*

Section 5(e). Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits and $500 per person ($1,000 per family) for Out-of Network benefits. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- In addition to any applicable deductible and copayment or coinsurance described for Out-of-Network benefits, you will be responsible for any charges in excess of the Non-Network provider allowance amount.

YOU MUST GET PRIOR APPROVAL FOR MENTAL HEALTH AND SUBSTANCE ABUSE INPATIENT SERVICES. Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic testing • Intensive outpatient programs	**In-Network: no deductible** $15 per individual visit $10 per group visit **Out-of-Network:** 40% of the Plan allowance
• Inpatient services provided by a hospital or other facility (including detoxification) • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	**In-Network:** $300 per hospital or facility admission (In-Network calendar year deductible applies) **Out-of-Network:**

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	
	40% of the Plan allowance (Out-of-Network calendar year deductible applies)
Hospital or facility based professional services Attending physician or psychologist	**In-Network:** 20% **Out-of-Network:** 40% of the Plan allowance
Not covered: • *Services for mental or substance abuse disorders not listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.* • *Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.* • *Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All Charges*

Prior Approval	To be eligible to receive inpatient benefits you must contact Medica Health Plans' desgnated provider, **Medica Behavioral Health**, and follow their treatment plan and network recommendations. Contact Medica Health Plans designated mental health and substance abuse provider at: • 1-800-848-8327 • TTY: 1-800-543-7162
Limitation	We may limit your benefits if you do not obtain a treatment plan.
Open Certification	To be eligible to receive outpatient benefits you must contact Medica Health Plans' desgnated provider, **Medica Behavioral Health**, and follow their treatment plan and network recommendations. Contact Medica Health Plans designated mental health and substance abuse provider at: • 1-800-848-8327 • TTY: 1-800-543-7162

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The In-Network calendar year deductible does not apply to this section. The calendar year deductible is $500 per person ($1,000 per family) for Out-of Network Benefits. The Out-of-Network deductible applies to all Out-of-Network benefits in this section.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. Specialty Drugs must be obtained at a designated vendor. The Specialty Drug list is available by calling Customer Services at 1-800-952-3455 or by visiting www.Medica.com.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor. We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-952-3455 or visit www.Medica.com.
  - **Generic** – A drug: (1) that is chemically equivalent to a brand name drug; or (2) that Medica identifies as a generic product. Classification of a drug as a generic is determined by Medica Health Plans and not by the manufacturer or pharmacy. A drug is classified as a generic based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your physician are classified by Medica Health Plans as generic.
  - **Brand name** – A drug: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that Medica Health Plans identifies as a brand name product. A drug is classified as a brand name based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your physician are classified by Medica Health Plans as brand name.
- **These are the dispensing limitations**
  - Prescription drugs, formulary OTC drugs, and supplies will not be dispensed in excess of one prescription unit except as described below. Three prescription units may be dispensed for drugs and supplies prescribed to treat chronic conditions that are received at a network pharmacy that Medica Health Plans has specifically designated to dispense multiple prescription units. For the current list of such designated pharmacies, call Customer Service at 1-800-952-3455. This list is also available on www.medica.com. When you have used 75 percent of your prescription (65 percent for Specialty Drugs), you may refill your prescription before your refill date.
  - For prescription drugs and formulary OTC drugs, including smoking cessation products, one prescription unit is equal to:
    - Up to a 31-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica Health Plans' appropriate use guidelines);
    - Up to a 31 day suuply per type of insulin; or
    - A one-cycle supply of oral contraceptives.
  - For diabetic supplies, one prescription unit is equal to the greater of:
    - Up to a 31-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica Health Plans' appropriate use guidelines); or

- 100 units.
- Mail Order- through this program, you may receive up to 90-day supply of maintenance medications for drugs which require a prescription. Some medications may not be available in a 90-day supply even though the prescription is for 90 days. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength since the previous purchase. Refills orders submitted too early after the last one was filled are held unless prior arrangements have been made. Please contact our designated pharmacy vendors, Bioscrip at 1-800-677-4323 or Walgreens Mail Service at 1-800-635-3070 for additional information.

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of the drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity strength, and effectiveness. A generic costs you less, however you and your doctor have the option to request a brand name even if a generic is available.
- **What are specialty prescription drugs?** Specialty prescription drugs include but are not limited to high technology prescription drug products for individuals with diseases that require complex therapies. Many specialty drugs require special handling, close patient monitoring, and in most cases are prescribed by specialists. Examples of conditions and a prescription drug used to treat the condition include, but are not limited to: Blood disorders (Procrit), Crohn's Disease (Humira), Cystic Fibrosis (Pulmozyme), Growth Hormone (Genotropin), Hepatitis (Pegasys), Infertility (chorionic gonadotropin), Multiple Sclerosis (Betaseron), Rheumatoid Arthritis (Enbrel). For a complete list of specialty prescripition drugs call Customer Service at 1-800-952-3455 or visit www.medica.com.
- **How are specialty prescription drugs obtained?** To receive coverage for specialty prescription drugs, you must obtain the drug through Medica's designated prescription drug pharmacy - Walgreens Specialty Pharmacy. Walgreens Specialty Pharmacy allows you the convenience of home delivery, or the option to pick up most prescriptions at your local Walgreens retail store. Walgreens Specialty Pharmacy will provide resources and support to help you achieve the best results from your prescribed therapy.
- **Exceptions for special circumstances** Medica Health Plans will authorize up to 90-day supply at a network pharmacy for covered persons called to active military service. Also, Medica Health Plans will authorize an extra 30-day supply for civilian Government employees who are relocated for assignment in the event of a national emergency. Authorization may be obtained from Medica Health Plans at 1-800-952-3455.
- **When you do have to file a claim.** You do not need to file a claim for drugs obtained at a network pharmacy or through our mail order service. You would need to file a claim for prescription drugs covered as part of an out of area emergency, if you did not get them at a network pharmacy. See Section 7 for instructions on filing a claim.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Formulary OTC drugs • Insulin • Drugs for sexual dysfunction • Contraceptive drugs, devices, and diaphragms • Smoking Cessation	**In-Network: no deductible** • $10 Generic Formulary • $25 Brand Formulary • $50 Brand Non-Formulary **Out-of-Network:** • Member pays the greater of 40% of the Plan allowance or $50 per prescription unit. Note: If there is no generic equivalent available, you will still have to pay the brand name copay

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
We cover the following supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Diabetic supplies including blood glucose monitors • Disposable needles and syringes	**In-Network: no deductible** • 20% Generic Formulary • 20% Brand Formulary • 40% Brand Non-Formulary **Out-of-Network:** • 40% of the Plan allowance
Specialty Prescription Drugs Such as: • Growth hormones • Infertility Note: See *What are specialty prescription drugs?* section above for additional information.	**In-Network: no deductible** • 20% Formulary - maximum of $200 per prescription or refill • 40% Non-Formulary **Out-of-Network:** • No Coverage
Medica Health Plans uses two designated pharmacy vendors, **BioScrip** and **Walgreens Mail Service**, for our prescription mail order program. Please visit www.medica.com for additional information. We cover the following medications and supplies prescribed by a Plan physician and obtained through our **mail order program**: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Drugs for sexual dysfunction • Contraceptive drugs, devices, and diaphragms • Smoking Cessation	**In-Network:no deductible** • $20 Generic Formulary • $50 Brand Formulary • $100 Brand Non-Formulary **Out-of-Network:** • No Coverage
Not covered: • *Any amount above what Medica Health Plans would have paid when you fail to identify yourself to the pharmacy as a member.* • *OTC drugs that by federal or state law do not require a prescription order or refill and any medication that is equivalent to an OTC drug (except OTC drugs that are on the formulary and that are received as described in this section).* • *Replacement of a drug or supply due to loss, damage or theft*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• *Appetite suppressants* • *Drugs and supplies prescribed by a provider who is not acting within their scope of licensure.* • *Homeopathic medicine* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them.* • *Nonprescription medicines*	*All Charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care. There are no Out-of Network Benefits available.
- The calendar year deductible is: $250 per person ($500 per family) for In-Network Benefits. The calendar year deductible applies to **all** benefits in this Section.
- Coverage is available for medical-related dental services only under this Plan.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. • 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. Note: In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.	**In-Network:** 20% **Out-of-Network:** No Coverage
Charges for medical facilities and general anesthesia services that are: • Recommended by a network physician; and • Received during a dental procedure; and • Provided to a member who: - Is a child under age five (prior authorization is *not* required); or - Is severely disabled; or - Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Note**:** Age, anxiety and behavioral conditions are not considered medical conditions for facility services and general anesthesia.	**In-Network:** 20% **Out-of-Network:** No Coverage
Not covered:	*All charges*

Accidental injury benefit - continued on next page

Benefit Desription	You Pay
Accidental injury benefit (cont.)	
• *Preventive and comprehensive dental services* • *Any orthodontia including that associated with orthognathic procedures, accident-related dental injuries, or temporomandibular joint (TMJ) disorder. However, this exclusion does not apply when orthodontia is used as secondary treatment for TMJ disorder in cases where primary treatment has been completed and lack of orthpedic (tooth) support has caused additional episodes of TMJ disorder.*	*All charges*
Dental benefits	

We do not offer preventive or comprehensive dental benefits under this plan.

Section 5(h). Special features

Feature	Description
Health Coaching	Health coaching is: • Member/patient-centric and about meeting the member/patient where they are in their readiness to change or management of their condition/health/lifestyle. • Working with members/patients to clarify what they want to accomplish and coaching them to break down their barriers and ambivalence about change. • Finding the strengths within people and building upon those to support them in making healthier lifestyle decisions and in self-management. • Empowering the member/patient to manage their health. Contact Customer Service at 1-800-952-3455 for additional information.
Medica CallLink Nurse Line	Help with health concerns is available 24 hours a day, 365 days a year by calling a toll free number 1-800-962-9497 and through TTY 1-800-855-2880. The service offers health advice or health information regarding: • Routine illnesses • Chronic conditions • Minor injuries • Medication questions • Smart food choices • Staying healthy
Services for deaf and hearing impaired	Medica Health Plans provides TTY 1-800-841-6753 access for the hearing impaired to access information and receive answers to questions
Comprehensive Online Information • **www.medica.com** • **www.mymedica.com**	Two online resources to: • Maximize your benefits • Save time and money • Make better health care decisions www.medica.com • 24 hour access to provider information, health information and much more www.mymedica.com • 24 hour access to online information regarding your coverage, claims, network providers, and other useful information • Maximize your benefits • Save time and money • Make better health care decisions
Healthy Pregnancy Program	Medica Health Plans' Healthy Pregnancy program is available to pregnant members. Contact Customer Service at 1-800-952-3455 to participate

My Health Manager	Whether you want to adopt a more balanced diet, control your blood pressure, manage stress or work some exercise into your daily routine, it's easy to get the results you want with My Health ManagerSM from Medica. Track your online and offline wellness activities to earn wellness credits. When you earn at least 25 wellness credits per quarter, you'll receive a $25 gift card to spend with familiar merchants. To register, go the www.medica.com and click on "My Health Manager from Medica" under Top Member Resources.
Fit ChoicesSM	Fit Choices from Medica is a health club credit program in which Medica Health Plans provides a $20 credit towards health club membership monthly dues when a member visits the facility eight or more days per calendar month. Eligible members must have a health club membership that costs a minimum of $20 after applied taxes on average per month to enroll into the program. Contact Customer Service at 1-800-952-3455 or visit www.medica.com.
Treatment Decision Support	A service provided by Medica Health Plans to assist members with questions about their treatment options for the following conditions: low back pain, knee or hip replacement, chronic stable angina, benign uterine conditions, benign prostatic hypertrophy and prostate cancer. Contact Customer Service at 1-800-952-3455 to participate.
Disease Management	Common disease program (HF, CAD, Pediatric Asthma, Diabetes for adults) / Rare disease program- for fourteen disease states including Multiple Sclerosis, Parkinson's Disease, Rheumatoid Arthritis. Contact Customer Service at 1-800-952-3455 for additional information.
Smoking Cessation Programs	Medica Health Plans offers programs designed to ease the transition and help you become tobacco-free. All members of Medica Health Plans have access to a convenient and free-of-charge tobacco cessation phone support service. Contact Medica Tobacco Cessation Program at 1-800-934-4824 for more information or contact Customer Service at 1-800-952-3455 and request the Medica Tobacco Cessation Program Brochure.
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 1-800-952-3455 or visit their website at www.medica.com.

No applicable benefits at this time.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants)**.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Autopsies;
- Services by persons who are family members or who share your legal residence;
- Services for which coverage is available under workers' compensation maximum benefit, or any similar law;
- Unless requested by Medica Health Plans, charges for duplicating and obtaining medical records from non-network providers and non-network dentists;.
- Photographs, except for the condition of multiple dysplastic syndrome;
- Exams, other evaluations or other services for judicial or administrative proceedings or research (except emergency examination of a child ordered by judicial authorities) unless otherwise covered under this Plan;
- Coverage for costs associated with translation of medical records and claims to English; or
- Services and supplies received from or ordered by a non-recognized. ineligible provider. See pg 10 for additional information on providers.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services or Out-of-Network services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-952-3455.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Medica Health Plans

PO Box 30990

Salt Lake City, UT 84130

Prescription drugs

Submit your claims to:

Medica Health Plans

10680 Treena Street 5th Floor

San Diego, CA. 92131

Other supplies or services

Submit your claims to:

Medica Health Plans

PO Box 30990

Salt Lake City, UT 84130

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Medica Health Plans Customer Service, Route 0501, PO Box 9310, Minneapolis, MN., 55440-9310 ; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

	Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-952-3455 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-952-3455 or see our Web site at www.medica.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: : You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when our Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in another Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Worker's Compensation

We do not cover services that:

- You need because of a work place-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similary agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services an supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you reimburse us for any expense we paid. However we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

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

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.

Durable Medical Equipment

Equipment and supplies that are:

- Are prescribed by your physician (i.e. the physician who is treating your illness or injury);
- Are medically necessary;
- Are primarily and customarily used only for a medical purpose;
- Are generally useful only to the person with an illness or injury;
- Are designed for prolonged use; and
- Serve a specific therapeutic purpose in the treatment of an illness or an injury

Experimental or investigational service

This Plan determines if a treatment or procedure is experimental/investigative or unproven if it is:

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

- 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;
- 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

- 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 Health Plans to be investigative. Medica Health Plans 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*.

Medical necessity

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:

- 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
- Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and
- Help to restore or maintain your health; or
- Prevent deterioration of your condition; or
- Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Member

A person who is enrolled under the Plan.

Network

A term used to describe a provider (such as a hospital, physician, home health agency, skilled nursing facility or pharmacy) that has entered into a written agreement with Medica Health Plans or has made other arrangements with Medica Health Plans to provide benefits to you. The participation status of providers will change from time to time.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

The amount that Medica Health Plans will pay to a participating provider for each benefit is equal to the lesser of the:

- Provider's charge; or
- Provider's Contracted Rate

The amount that Medica Insurance Company (MIC) will pay on behalf of Medica Health Plans to a Non-Network provider for each benefit is equal to the lesser of the:

- Provider’s charge; or
- Amount MIC determines, based on prevailing reimbursement rates or marketplace charges, for similar services and supplies, in the geographic area in which the benefit is provided; or
- Amount agreed upon between MIC and the non-network provider.

Us/We

Us and We refer to Medica Health Plans.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31st day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incure eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimium annual election of $250 and a maximum annual election is $5,000.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHB or FEDVIP coverage or any other insurance. .
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all of the following:

- Class A (Basic) services which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions and denture adjustments.
- Class C (Major) services which include endodontic services such as root canals, periodontal services such as gingivectomy major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.OPM.gov/insure/dentalvision/. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the Medica Health Plans- 2009

- **Do not rely on this chart alone**. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the calendar year deductible $250 per person ($500 per family) for In-Network Benefits and $500 per person ($1,000 per family) for Out-of Network benefits. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Out-of-Network physician or other health care professional.

Benefits	You pay	Page
In-network medical preventive care	Nothing	21
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	**In-Network:** $15 per office visit **Out-of-Network:** 40% of the Plan allowance*	20
Services provided by a hospital:		
• Inpatient	**In-Network:** $300 per hospital or facility admission* **Out-of-Network:** 40% of the Plan allowance*	41
• Outpatient	**In-Network:** 20% of the Plan Allowance* **Out-of-Network:** 40% of the Plan Allowance*	42
Emergency benefits:		
• In-area	$75 per emergency room visit $15 per urgent care center visit	47
• Out-of-area	20% of the Plan allowance* (In-Network deductible applies)	47
Mental health and substance abuse treatment:	Regular cost sharing	49
Prescription drugs:		
• Retail pharmacy	**In-Network:** • $10 Generic Formulary • $25 Brand Formulary • $50 Brand Non-Formulary	52

Summary of benefits continued...

Benefits	Description	Page

Benefits	Description	Page
• Retail pharmacy	**Out-of-Network:** • Member pays greater of 40% of the Plan allowance or $50 per unit.*	52
• Mail order	**In-Network:** • $20 Generic Formulary • $50 Brand Formulary • $100 Brand Non-Formulary **Out-of-Network:** • No Coverage	53
Dental care:		
• Accidental injury	**In-Network:** 20% of the Plan Allowance* **Out-of-Network:** No Coverage	55
Vision care:		
• **Annual eye refraction**	**In-Network:** Nothing **Out-of-Network:** No Coverage	27
Special features:		
• Health Coaching • Medica CallLink Nurse Line • Services for deaf and hearing impaired • Comprehensive Online Information • Healthy Pregnancy Program • Fit Choices SM • My Health Manager • Treatment Decision Support • Disease Management • Smoking Cessation Programs • Flexible Benefits Option	Nothing	57
Protection against catastrophic costs (out-of-pocket maximum)**:**	**In-Network:** $3,000 per person or $5,000 per family in any calendar year **Out-of-Network:** $5,000 per person in any calendar year	15

Notes

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2009 Rate Information for Medica Health Plans

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career* United States Postal employees, RI 70-2, and the rates shown below.

The rates shown below do not apply to *Postal* Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	M21	$155.66	$69.15	$337.26	$149.83	$179.45	$45.36
High Option Self and Family	M22	$352.56	$162.24	$763.88	$351.52	$406.42	$108.38