McLEOD COUNTY
BOARD OF COMMISSIONERS
PROPOSED MEETING AGENDA
FEBRUARY 16, 2016

1 9:00 CALL TO ORDER

PLEDGE OF ALLEGIANCE

RETIREMENT RECOGNITION

Recognition of Social Worker Jerry Schimelpfenig's retirement and presentation of a plaque in appreciation for his nineteen years of service to the McLeod County Social Service Department from August 1, 1996 through February 16, 2016.

RECOGNITION

Recognition from the 2016 President of the Minnesota County Engineers Association Mark Krebsbach of County Engineer John Brunkhorst who was recognized by his peers as the Minnesota County Engineer of the Year for 2015.

2 9:03 CONSIDERATION OF AGENDA ITEMS*

3 9:08 CONSENT AGENDA*

A. February 2, 2016 Meeting Minutes and Synopsis.
B. January 29, 2016 Auditor's Warrants.
C. February 4, 2016 Auditor's Warrants.
D. February 5, 2016 Auditor's Warrants.

4 PAYMENT OF BILLS - COMMISSIONER WARRANT LIST*

5 PAYMENT OF BILLS - ADDITIONAL MISCELLANEOUS BILLS TO BE PAID BY AUDITORS WARRANTS*

6 9:10 ROAD AND BRIDGE – Highway Engineer John Brunkhorst

A. Consider final acceptance and payment of $4,467.06 to Midwest Contracting LLC (Marshall, MN) for the following construction projects with funding coming from County, Bridge Bonding, Township and Town Bridge Funds:*

1. SAP 43-598-014, Box Culvert Construction on CR 58
2. SAP 43-599-041, Box Culvert Construction on Eagle Avenue in Winsted Township
3. SAP 43-599-042, Box Culvert Construction on Grass Lake Road in Winsted Township

These projects were completed satisfactorily and final acceptance and payment is recommended.

B. Consider county maintenance costs associated with patching and frost boil repairs done on the 2014 improvement project on Sunset Circle and North Sunset Drive in Collins Township.*

County labor:	$3,812.83
County Equipment:	$5,154.75
County Material:	$1,139.55
Gravel Test:	$ 114.99
	$10,222.12

These repairs were done to maintain the integrity of the improved surface.

C. Consider approval of sealcoat on Sunset Circle and North Sunset Drive in Collins Township with a not to exceed cost of $20,000; contingent upon Township approval and the Township covering costs above $20,000.*

In 2014 the price for the sealcoat was $27,100 for the same segments of road.

D. Consider approval to hire Stonebrooke Engineering (Burnsville, MN) for engineering services related to replacement of bridge 43001 on Hamlet Avenue in Glencoe Township for a not to exceed fee of $95,125 (based on hourly rates) with funding coming from Township and Town Bridge Funds.*

Cost breakdown:
Design engineering: $35,150
Construction Engineering: $59,975

Additional quote received: Erickson Engineering (Bloomington, MN) $107,397.

Bridge 43001 is structurally deficient and Glencoe Township has authorized replacement.

E. Consider approval to purchase a 2017 Mack tandem truck chassis from Nuss Truck and Equipment (Roseville, MN) (State Contract T-647(5)) for $124,231.64 with funding coming from the 2016 Highway budget.*

This truck would replace a 1997 Ford L9000 with 210,000 miles.

F. Consider approval to purchase truck equipment package (box, plow, scraper, wing, sander, misc.) from Towmaster, Inc. (Litchfield, MN) or $113,841 (State Contract S-863(5)) for $113,841 with funding coming from the 2016 Highway budget.*

G. Consider approval to sell a 1997 Ford L9000 plow truck (plow, sander, wing) for a minimum bid of $12,780. (this represents the trade value toward the new Mack, if we can't sell it for the minimum bid, we will trade it).*

7 9:30 PUBLIC HEARING – City of Stewart - North Connector Road Project

A. Consider adoption of Resolution 16-CB-08 Property Tax Abatement for Certain Property Located in McLeod County.*

8 9:45 ASSESSORS OFFICE – County Assessor Sue Schulz

A. Consider approval of payment of $10,000 for project manager for new tax and CAMA System with funding coming from the Compliance Fund.*
B. Presentation of settlement offer for Central National Bank – parcel number 23.036.4200 for payable year 2013.

9 10:00 JAIL RENOVATION & COURTHOUSE SECURITY – Wold Architect John McNamara and Contegrity Group Construction Manager Larry Filippi

A. Presentation and consideration of bid approvals for jail renovation and security project.*

10 10:30 PUBLIC HEARING – Notice of Hearing on Repair Petition CD #26 and CD #27

A. Consider Engineers Repair Report.*

11 10:45 PLANNING AND ZONING – Administrator Larry Gasow

A. Consider approval of Conditional Use Permit 16-01 requested by CleodSun LLC on behalf of SunShare, LLC as an Essential Service on property owned by Steinkraus Lester Prairie LLC for the purpose of a Community Solar Garden. SunShare, LLC is planning an up to a 3 Megawatt (MW) garden upon approval by Xcel Energy of their application to provide them with renewable energy on the Xcel Energy power grid. The proposed Solar Garden meets all setbacks and requirements of the Zoning Ordinance. The property will be fenced for security and safety reasons. Appropriate applications shall be submitted to local and State Agencies. This property is located within approximately 25 AC parcel in NW ¼ of NE ¼ of Section 32, Winsted Township.

   Winsted Township did not make recommendation of the proposed application at their regular meeting on January 14, 2016 due to the request for additional information, which was provided on January 22, 2016.

   On January 27, 2016, the Planning Advisory Committee recommended approval by majority vote being taken In Favor - 2; being In Opposition - 1, with the following conditions being applied:

   1. Proof of Insurance shall be provided to the Zoning Office prior to any permits being issued.
   2. A Bond or Letter of Credit in the amount of $60,000 shall be submitted to the Zoning Office prior to any permits being issued. (3 MW @ $20,000 each = $60,000.

3. Copy of MnDOT proposal granting access to utilize the gravel access road to site location shall be provided to the Zoning Office prior to any permits being issued.
4. Xcel Energy shall check for stray voltage on site and neighboring sites on a monthly basis for one year. A copy shall be provided to the Zoning Office.
5. A contact person for noxious weeds and other concerns shall be identified by a placard sign at the sight with contact name and phone number.
6. A contact name shall be provided to the Zoning Office for decommission and reclamation once the essential service is no longer in use.
7. A landscape buffer plan and vegetative management plan shall be provided to the Zoning Office.
8. A wetland Delineation shall be performed by contacting Environmental Services Officer.
9. Applicant shall meet all NPDES Permit requirements.
10. Agricultural fencing with two strands barbed wire shall be installed for site safety and security.

12 11:30 INFORMATION TECHNOLOGY – Director Vince Traver

A. Consider approval for a three year agreement with Morris Electronics to provide and maintain a Zix email encryption server. The Quote specifies a cost of 200 seats at $5000.00 a year for three years with funding coming from the 2016 Infromation Technology budget.*

   Zix, our current vendor, quoted a three year agreement at $12,455 per year for a three year contract.

   Zix encryption is our chosen application for encrypting emails sent outside of our organization to make sure emails containing secure information are not intercepted by anyone else. The Morris Electronics quote would be a savings of $7455.00 per year for a total of $22365.00. It will also save us some administration time for not having to support the onsite server.

13 11:35 HUMAN RESOURCES – Director Mary Jo Wieseler

A. Consider February 9, 2016 Personnel Committee Recommendations.*
B. Consider approval to hire full-time Communications Officer (grade 15) due to resignation.*
C. Consider approval for Personal Leave due to a medical condition. Employee has exhausted FMLA Leave and is currently on a 30 day Personal Leave. To extend beyond 30 days requires Board approval, which would be Feb 23 – March 10.*
D. Consider approval of the 2016 Plan Document for the Silver Plan.*
E. Consider approval of the 2016 Plan Document for the Bronze Plan.*
F. Consider approval of the 2016 Plan Document for the HSA Plan.*
G. Consider approval of the Medica Administrative Services Agreement.*
H. Consider approval of the Medica Stop Loss Agreement.*

14 COUNTY ADMINISTRATION

- Review of Commissioners Calendar
- Commissioner reports of committee meetings attended since February 2, 2016.

A. Approval of additional appointments for 2016 Committees.*
B. Consider correction to 2016 bids for official newspaper.*
C. Update on proposed March Workshop.

OTHER

Open Forum
Press Relations

RECESS

Next board meeting March 1, 2016 at 9:00 a.m. in the County Boardroom.

McLEOD COUNTY
BOARD OF COMMISSIONERS
PROPOSED MEETING MINUTES – February 2, 2016

CALL TO ORDER

The regular meeting of the McLeod County Board of Commissioners was called to order at 9:00 a.m. by Chair Paul Wright in the County Board Room. Commissioners Nies, Shimanski, Nagel and Krueger were present. County Administrator Patrick Melvin, Administrative Assistant, Donna Rickeman and County Attorney Michael Junge were also present.

PLEDGE OF ALLEGIANCE

At the request of the Board Chair, all present recited the Pledge of Allegiance.

INTRODUCTION OF NEW EMPLOYEE

Tasha Schiedel started employment as McLeod for Tomorrow Coordinator on January 5, 2016.

CONSIDERATION OF AGENDA ITEMS

A) Add under Administration Item G: Consider approval of Ed Homan's last day of employment retroactive to January 7, 2016.
B) Add under Administration Item H: Consider approval of gambling permit for Plato Fire Department Relief Association., 112 2nd Ave NE, Plato, MN to conduct a raffle on February 19, 2016 at Plato Community Hall, 120 1st Ave NE, Plato, MN.

Nies/Krueger motion carried unanimously to approve the agenda as revised.

CONSENT AGENDA

A) January 19, 2016 Meeting Minutes and Synopsis.
B) January 15, 2016 Auditor's Warrants.
C) January 15, 2016 Special Auditor's Warrants.
D) January 22, 2016 Auditor's Warrants.
E) Approve an application and permit for a 3 day temporary on-sale liquor license for Winstock Country Music Festival, Winsted, Minnesota for their event being held on June 9-11th, 2016 at 230th St., Winsted, Minnesota.
F) Approve gambling permit for Church of the Holy Trinity, 111 Winsted Ave. W., Winsted, MN to conduct pull-tabs on June 9-11th, 2016 at the Winstock

Music Festival located at 230th St., Winsted, Minnesota. The application is acknowledged with no waiting period.

G) Approve gambling permit for Shady Lane Sportsmen's Club Inc., 8376 Falcon Ave., Box 41, Glencoe, MN to conduct a raffle on June 17-18th, 2016 at McLeod County Fairgrounds, 840 Century Ave. SW, Hutchinson, MN. The application is acknowledged with no waiting period.

Nies/Krueger motion carried unanimously to approve the consent agenda.

PAYMENT OF BILLS – COMMISSIONER WARRANT LIST

General Revenue	$85,763.45
Road & Bridge	$37,908.09
Solid Waste	$47,416.29

Shimanski/Krueger motion carried unanimously to approve payment of bills totaling $171,087.83 from the aforementioned funds.

ROAD AND BRIDGE – Highway Engineer John Brunkhorst

A) John Brunkhorst requested final acceptance and payment of $10,850.81 to Traffic Marking Services (Maple Lake, MN) for the following construction projects with funding coming from County and Federal Funds:

1. SP 43-070-009, County wide ground in wet reflective edgeline (~24 miles)
2. SP 43-070-010, County wide edgeline (~90 miles)

These projects were completed satisfactorily and final acceptance and payment is recommended.

Shimanski/Krueger motion carried unanimously to approve final acceptance and payment of $10,850.81 to Traffic Marking Services (Maple Lake, MN) for the above listed construction projects with funding coming from County and Federal Funds.

B) John Brunkhorst requested final acceptance and payment of $168,958.59 to Knife River (Sauk Rapids, MN) for the following construction projects with funding coming from County and State Aid:

1. SAP 43-617-009, Reclaim/Bituminous Overlay on CSAH 17
2. SAP 43-626-005, Reclaim/Bituminous Overlay on CSAH 26

These projects were completed satisfactorily and final acceptance and payment is recommended.

Nagel/Nies motion carried unanimously to approve final acceptance and payment of $168,958.59 to Knife River (Sauk Rapids, MN) for the above listed construction projects with funding coming from County and State Aid.

C) John Brunkhorst requested adoption of Resolution 16-RB02-05 for the 2016-2018 bridge programs. The McLeod Highway Department has determined the following deficient bridges locations are a high priority and require replacement within the next few years: CSAH 24 Rich Valley, CSAH 11 Rich Valley and Hamlet Avenue Glencoe.

This is required by MnDOT State Aid. It is used by their office to prioritize bridges on a statewide level. It also helps them get a handle on the amount of bridge replacements statewide and the amount of funding needed when they approach the legislature.

Nies/Krueger motion carried unanimously to adopt Resolution 16-RB02-05 for the 2016-2018 bridge programs.

D) John Brunkhorst requested approval of MnDOT Agreement 1002292 and adoption of Resolution 16-RB03-06 for federal participation in advance construction for SP 43-604-014, 2016 rehabilitation project on CSAH 4.

McLeod County will be receiving federal funds for the CSAH 4 rehabilitation project in federal fiscal years 2016 & 2017. This agreement allows the County to construct the project in 2016 with available funds and receive the remaining portion of federal funds in federal fiscal year 2017.

Estimated Project cost:	$2,069,600
Federal Funds - FFY 2016:	$1,251,912
Federal Funds - FFY 2017:	$ 388,088
	$1,640,000 (~79% of project cost)

Shimanski/Nies motion carried unanimously to approve MnDOT Agreement 1002292 and adoption of Resolution 16-RB03-06 for federal participation in advance construction for SP 43-604-014, 2016 rehabilitation project on CSAH 4.

E) John Brunkhorst requested approval of agreement with Glencoe Township for replacement of bridge 43001 on Hamlet Avenue with funding coming from Township and Town Bridge Funds.

This is our standard agreement we do with the townships for bridge replacement projects. This agreement allows us to serve as the Townships representative in administrative, engineering, and construction phases of the project.

Krueger/Nagel motion carried unanimously to approve agreement with Glencoe Township for replacement of bridge 43001 on Hamlet Avenue with funding coming from Township and Town Bridge Funds.

HUMAN RESOURCES – Director Mary Jo Wieseler

A) Mary Jo Wieseler requested approval to hire full-time Technical Clerk (grade 12) in Public Health due to vacancy.

Nies/Shimanski motion carried unanimously to hire full-time Technical Clerk (grade 12) in Public Health due to vacancy.

B) Mary Jo Wieseler requested approval to hire full-time Social Worker – Chemical Dependency Rule 25 (grade 22) in Social Services due to lateral move to fill the current vacancy of an Adult Mental Health Social Worker.

Shimanski/Nagel motion carried unanimously to hire full-time Social Worker – Chemical Dependency Rule 25 (grade 22) in Social Services due to lateral move to fill the current vacancy of an Adult Mental Health Social Worker.

C) Mary Jo Wieseler requested approval to hire full-time Communications Officer (grade 15) in the Sheriff's Office due to a resignation.

Wright/Nies motion carried unanimously to hire full-time Communications Officer (grade 15) in the Sheriff's Office due to a resignation.

PUBLIC HEARING – 2016 Solid Waste Fee Schedule

A) Sarah Young presented the below proposed changes for the Solid Waste 2016 fee schedule.

Department	Fee	2015	2016	Justification
Solid Waste	Non-Contracted Single-Sort Processing Fee	NA	$35.00/ton	New fee pertaining to single-sort
Solid Waste	Out of County Agricultural Plastic Fee	NA	$40.00/ton	New fee pertaining to single-sort
Solid Waste	Special Cart Delivery Requests (more than one cart switch within a 12 month period)	NA	$20.00/each	New fee pertaining to single-sort
Solid Waste	Cart Replacement Cost - 95	NA	$60.00/each	New fee pertaining to single-sort

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Solid Waste	Cart Replacement Cost - 65	NA	$50.00/each	New fee pertaining to single-sort
Solid Waste	Cart Replacement Cost - 35	NA	$40.00/each	New fee pertaining to single-sort
Solid Waste	Mattresses	NA	$20.00/each	New fee added
Solid Waste	Box Springs	NA	$20.00/each	New fee added
Solid Waste	Crib Mattresses	NA	$7.00/each	New fee added
Solid Waste	Tires (light car and/or truck only)	NA	$3.00/each	New fee added
Solid Waste	Rims	NA	$2.00/each	New fee added
Solid Waste	Electronic Items (laptop and larger)	NA	$10.00/each	New fee added
Solid Waste	Appliances	NA	$10.00/each	New fee added
Solid Waste	Miscellaneous Cylinders	NA	Vendor Pricing	New fee added
Solid Waste	Artificial Christmas Tree	NA	$5.00/each	New fee added
Solid Waste	Carpet/Carpet Padding	NA	$20.00/roll	New fee added

Nies/Wright motion carried unanimously to approve the proposed 2016 Solid Waste fee schedule as presented.

COUNTY ADMINISTRATION

A) Pat Melvin requested approval to set the 2017 Voluntary Premium Credit of $15 a month. Employees who participate in three wellness activities between January 1 and October 31, 2016 will earn a $15 a month credit towards their health care premium.

Nagel/Shimanski motion carried unanimously to set the 2017 Voluntary Premium Credit of $15 a month. Employees who participate in three wellness activities between January 1 and October 31, 2016 will earn a $15 a month credit towards their health care premium.

B) Donna Rickeman requested approval of the following committee appointment changes:

Betty Stras replaces Craig Glieden on the Insurance Committee
Eric Westlund replaces Frank Fay on Housing and Redevelopment Authority
Adam Griebe replaces Dan Rickert on Parks Committee not Extension

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Nagel/Shimanski motion carried unanimously to approve the committee appointment changes as presented.

C) Pat Melvin requested adoption of Resolution 16-CB-07 for endorsement of the revised County Program Aid formula developed by the Association of Minnesota Counties' County Program Aid Work Group.

Minnesota has a tradition of state-mandated, county-administered programming that requires counties to deliver essential services in public safety, human services, transportation and other vital program areas on the states behalf. To help pay for these services, the state distributes funding to counties via County Program Aid (CPA) with the additional goal of potentially offsetting county tax levy growth.

The Association of Minnesota Counties (AMC) convened a work group to study the CPA formula and recommend improvements. The following is a summary of the changes recommended by the group: a funding increase of $40 million, the creation of a funding floor that guarantees each county $350,000 in Tax Base Equalization Aid (TBEA), elimination of special funds and transition aid and the creation of a 5% cap on annual CPA losses.

Shimanski/Wright motion carried unanimously to adopt Resolution 16-CB-07 for endorsement of the revised County Program Aid formula developed by the Association of Minnesota Counties' County Program Aid Work Group.

D) Pat Melvin led discussion on the 2016 Student Government Day. It was agreed that McLeod County would try to host this day in April to avoid all the school testing that is typically held during the month of May. Commissioner Krueger and Nagel volunteered to be in charge of contacting schools to work out the details.

E) Pat Melvin notified the board of an upcoming workshop scheduled for February 18th at 9:30 A.M. to discuss Pay for Performance.

F) Pat Melvin notified the board of the 2016 Local Government Legislative Conference scheduled for March 10th and 11th in St Paul.

G) Pat Melvin requested approval of Ed Homan's last day of employment retroactive to January 7, 2016.

Nies/Krueger motion carried unanimously to approve Ed Homan's last day of employment retroactive to January 7, 2016.

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H) Pat Melvin requested approval of gambling permit for Plato Fire Department Relief Association., 112 2nd Ave NE, Plato, MN to conduct a raffle on February 19, 2016 at Plato Community Hall, 120 1st Ave NE, Plato, MN.

Krueger/Nies motion carried unanimously to approve gambling permit for Plato Fire Department Relief Association., 112 2nd Ave NE, Plato, MN to conduct a raffle on February 19, 2016 at Plato Community Hall, 120 1st Ave NE, Plato, MN.

Krueger/Wright motion carried unanimously to recess at 10:15 a.m. until 9:00 a.m. February 16, 2016 in the County Boardroom.

ATTEST:

_____ _____

Paul Wright, Board Chair Patrick Melvin, County Administrator

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McLEOD COUNTY
BOARD OF COMMISSIONERS
SYNOPSIS – February 2, 2016

1. Commissioners Wright, Nies, Shimanski, Krueger and Nagel were present.
2. Nies/Krueger motion carried unanimously to approve the agenda as revised.
3. Nies/Krueger motion carried unanimously to approve the consent agenda including January 19, 2016 Meeting Minutes and Synopsis; January 15, 2016 Auditor's Warrants; January 15, 2016 Special Auditor's Warrants; January 22, 2015 Auditor's Warrants; Approve an application and permit for a 3 day temporary on-sale liquor license for Winstock Country Music Festival, Winsted, Minnesota for their event being held on June 9-11th, 2016 at 230th St., Winsted, Minnesota; Approve gambling permit for Church of the Holy Trinity, 111 Winsted Ave. W., Winsted, MN to conduct pull-tabs on June 9-11th, 2016 at the Winstock Music Festival located at 230th St., Winsted, Minnesota. The application is acknowledged with no waiting period; Approve gambling permit for Shady Lane Sportsmen's Club Inc., 8376 Falcon Ave., Box 41, Glencoe, MN to conduct a raffle on June 17-18th, 2016 at McLeod County Fairgrounds, 840 Century Ave. SW, Hutchinson, MN.
4. Shimanski/Krueger motion carried unanimously to approve payment of bills totaling $171,087.83 from the aforementioned funds.
5. Shimanski/Krueger motion carried unanimously to approve final acceptance and payment of $10,850.81 to Traffic Marking Services (Maple Lake, MN) for the above listed construction projects with funding coming from County and Federal Funds.
6. Nagel/Nies motion carried unanimously to approve final acceptance and payment of $168,958.59 to Knife River (Sauk Rapids, MN) for the above listed construction projects with funding coming from County and State Aid.
7. Nies/Krueger motion carried unanimously to adopt Resolution 16-RB02-05 for the 2016-2018 bridge programs.
8. Shimanski/Nies motion carried unanimously to approve MnDOT Agreement 1002292 and adoption of Resolution 16-RB03-06 for federal participation in advance construction for SP 43-604-014, 2016 rehabilitation project on CSAH 4.
9. Krueger/Nagel motion carried unanimously to approve agreement with Glencoe Township for replacement of bridge 43001 on Hamlet Avenue with funding coming from Township and Town Bridge Funds.
10. Nies/Shimanski motion carried unanimously to hire full-time Technical Clerk (grade 12) in Public Health due to vacancy.
11. Shimanski/Nagel motion carried unanimously to hire full-time Social Worker – Chemical Dependency Rule 25 (grade 22) in Social Services due to lateral move to fill the current vacancy of an Adult Mental Health Social Worker.
12. Wright/Nies motion carried unanimously to hire full-time Communications Officer (grade 15) in the Sheriff's Office due to a resignation.

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13. Nies/Wright motion carried unanimously to approve the proposed 2016 Solid Waste fee schedule as presented.

14. Nagel/Shimanski motion carried unanimously to set the 2017 Voluntary Premium Credit of $15 a month. Employees who participate in three wellness activities between January 1 and October 31, 2016 will earn a $15 a month credit towards their health care premium.

15. Nagel/Shimanski motion carried unanimously to approve the committee appointment changes as presented.

16. Shimanski/Wright motion carried unanimously to adopt Resolution 16-CB-07 for endorsement of the revised County Program Aid formula developed by the Association of Minnesota Counties' County Program Aid Work Group.

17. Nies/Krueger motion carried unanimously to approve Ed Homan's last day of employment retroactive to January 7, 2016.

18. Krueger/Nies motion carried unanimously to approve gambling permit for Plato Fire Department Relief Association., 112 2nd Ave NE, Plato, MN to conduct a raffle on February 19, 2016 at Plato Community Hall, 120 1st Ave NE, Plato, MN.

Complete minutes are on file in the County Administrator's Office. The meeting recessed at 10:15 a.m. until February 16, 2016.

Attest:

_____ _____

Paul Wright, Board Chair Patrick Melvin, County Administrator

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********* McLeod County IFS *********

Audit List for Board AUDITOR'S VOUCHERS ENTRIES

Print List in Order By: 2

1 - Fund (Page Break by Fund)
2 - Department (Totals by Dept)
3 - Vendor Number
4 - Vendor Name

Page Break By: 1

1 - Page Break by Fund
2 - Page Break by Dept

Explode Dist. Formulas Y

Paid on Behalf Of Name on Audit List?: N

Type of Audit List: D

D - Detailed Audit List
S - Condensed Audit List

Save Report Options?: N

Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
0	DEPT			...		
	1241 MADISON NATIONAL LIFE INSURANCE C					
29	01-000-000-0000-2041		1,464.18	STD PREMIUM GENERAL FUND 01/01/2016 01/31/2016		Short Term Disability Payable
20	01-000-000-0000-2050		1,323.51	LTD PREMIUM GENERAL FUND 01/01/2016 01/31/2016		Long Term Disability Payable
	1241 MADISON NATIONAL LIFE INSURANCE C		2,787.69	2 Transactions		
	1360 MINNESOTA MUTUAL					
61	01-000-000-0000-2049		1,610.43	LIFE PREMIUM GENERAL FUND 01/01/2016 01/31/2016		Life Insurance Payable
	1360 MINNESOTA MUTUAL		1,610.43	1 Transactions		
	3093 TRUSTMARK VOLUNTARY BENEFIT SOLU					
103	01-000-000-0000-2049		1,770.74	JAUNARY BILLING		Life Insurance Payable
	3093 TRUSTMARK VOLUNTARY BENEFIT SOLU		1,770.74	1 Transactions		
0	DEPT Total:		6,168.86	...	3 Vendors	4 Transactions
3	DEPT			COUNTY WIDE		
	5281 TASC					
81	01-003-000-0000-6350		430.00	MARCH HSA PLAN ADMINISTRATION	IN720629	Other Services & Charges
82	01-003-000-0000-6350		444.40	MARCH FSA ADMINSTRATION	IN720629	Other Services & Charges
83	01-003-000-0000-6350		101.00	MARCH FSA CLAIM CARD FEES	IN720629	Other Services & Charges
	5281 TASC		975.40	3 Transactions		
3	DEPT Total:		975.40	COUNTY WIDE	1 Vendors	3 Transactions
13	DEPT			COURT ADMINISTRATOR'S		
	812 GAVIN WINTERS & LONG LTD					
14	01-013-000-0000-6273	AP 4	52.50	COURT APPT AS FA-14-1088	2007980-001M	Court Appt Atty-Other
6	01-013-000-0000-6272	AP 4	60.00	COURT APPT HW/JW/SW JV-15-139	20120122-000M	Court Appt Atty-Dep/Neg/Ter
7	01-013-000-0000-6272		105.00	COURT APPT HW/JW/SW JV-15-139	20120122-000M	Court Appt Atty-Dep/Neg/Ter
18	01-013-000-0000-6273	AP 4	11.25	COURT APPT FA FA-12-182	20130076-000M	Court Appt Atty-Other
94	01-013-000-0000-6272	AP 4	138.75	COURT APPT CR/RB JV-14-110	20143205-000M	Court Appt Atty-Dep/Neg/Ter
16	01-013-000-0000-6273	AP 4	71.25	COURT APPT SD FA-15-1463	20143321-001M	Court Appt Atty-Other
19	01-013-000-0000-6273	AP 4	33.75	COURT APPT GC FA-07-2679	20150117-000M	Court Appt Atty-Other
10	01-013-000-0000-6272	AP 4	15.00	COURT APPT JS/BB JV-15-95	20150194-000M	Court Appt Atty-Dep/Neg/Ter

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Vendor No.	Name / Account/Formula	Accr	Rpt	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
11	01-013-000-0000-6272			15.00	COURT APPT JS/BB JV-15-95	20150194-000M	Court Appt Atty-Dep/Neg/Ter
8	01-013-000-0000-6272	AP	4	1,065.00	COURT APPT AD/GD/AV JV-15-153	20150246-000M	Court Appt Atty-Dep/Neg/Ter
9	01-013-000-0000-6272			127.50	COURT APPT AD/GD/AV JV-15-153	20150246-000M	Court Appt Atty-Dep/Neg/Ter
3	01-013-000-0000-6272	AP	4	75.00	COURT APPT JG/PG/CY JV-15-156	20150254-000M	Court Appt Atty-Dep/Neg/Ter
17	01-013-000-0000-6273	AP	4	67.50	COURT APPT AG FA-15-1579	20150265-001M	Court Appt Atty-Other
12	01-013-000-0000-6272	AP	4	120.00	COURT APPT JK/CN JV-15-186	20150272-000M	Court Appt Atty-Dep/Neg/Ter
13	01-013-000-0000-6272			15.00	COURT APPT JK/CN JV-15-186	20150272-000M	Court Appt Atty-Dep/Neg/Ter
4	01-013-000-0000-6272	AP	4	135.00	COURT APPT CP/JD JV-15-189	20150276-000M	Court Appt Atty-Dep/Neg/Ter
5	01-013-000-0000-6272	AP	4	296.25	COURT APPT JK/CN JV-15-186	20150315-000M	Court Appt Atty-Dep/Neg/Ter
15	01-013-000-0000-6273	AP	4	150.00	COURT APPT TP PR-15-1820	20150333-000M	Court Appt Atty-Other
2	01-013-000-0000-6272	AP	4	198.75	COURT APPT DL/CV JV-15-159	20150334-000M	Court Appt Atty-Dep/Neg/Ter
812	GAVIN WINTERS & LONG LTD			2,752.50	19 Transactions		
3146	MELCHERT HUBERT SJODIN PLLP						
48	01-013-000-0000-6273	AP	4	60.00	COURT APPT DB FA-15-1579	123762	Court Appt Atty-Other
49	01-013-000-0000-6272	AP	4	90.00	COURT APPT KD/LA JV-13-146/164	123765	Court Appt Atty-Dep/Neg/Ter
50	01-013-000-0000-6272	AP	4	37.50	COURT APPT RM/DM/PF JV-14-191	123768	Court Appt Atty-Dep/Neg/Ter
51	01-013-000-0000-6272	AP	4	442.50	COURT APPT CR/RB JV-14-110	123770	Court Appt Atty-Dep/Neg/Ter
52	01-013-000-0000-6272	AP	4	67.50	COURT APPT MS/TS JV-15-154	123772	Court Appt Atty-Dep/Neg/Ter
44	01-013-000-0000-6273	AP	4	15.00	COURT APPT BW FA-08-1558	123773	Court Appt Atty-Other
53	01-013-000-0000-6272	AP	4	390.00	COURT APPT AB/DN JV-15-119	123782	Court Appt Atty-Dep/Neg/Ter
47	01-013-000-0000-6273	AP	4	255.00	COURT APPT SW FA-10-819	123783	Court Appt Atty-Other
54	01-013-000-0000-6272	AP	4	120.00	COURT APPT JO/SB JV-14-255	123784	Court Appt Atty-Dep/Neg/Ter
45	01-013-000-0000-6273	AP	4	217.50	COURT APPT AP PR-15-1523	123790	Court Appt Atty-Other
55	01-013-000-0000-6272	AP	4	495.00	COURT APPT CJ/BH/CR JV-15-196	123793	Court Appt Atty-Dep/Neg/Ter
46	01-013-000-0000-6273	AP	4	180.00	COURT APPT LB FA-15-1579	123794	Court Appt Atty-Other
3146	MELCHERT HUBERT SJODIN PLLP			2,370.00	12 Transactions		
6440	MELCHERT HUBERT SJODIN PLLP						
57	01-013-000-0000-6272	AP	4	225.00	COURT APPT SV/KV JV-15-68	123699	Court Appt Atty-Dep/Neg/Ter
58	01-013-000-0000-6272	AP	4	225.00	COURTA PPT LJ/CR JV-15-22	123700	Court Appt Atty-Dep/Neg/Ter
56	01-013-000-0000-6272	AP	4	60.00	COURT APPT RH/LH JV-12-205	123719	Court Appt Atty-Dep/Neg/Ter
6440	MELCHERT HUBERT SJODIN PLLP			510.00	3 Transactions		
4584	R J MCGRAW PA						
77	01-013-000-0000-6273			645.00	COURT APPOINT G VILLAON	PR-16-34	Court Appt Atty-Other
4584	R J MCGRAW PA			645.00	1 Transactions		

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	Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
13		DEPT Total:			6,277.50	COURT ADMINISTRATOR'S	4 Vendors	35 Transactions
41		DEPT				COUNTY AUDITOR-TREASURER'S		
	963	MINNESOTA STATE AUDITOR						
76		01-041-000-0000-6269	DTG	6	7,647.18	AUDIT ENDING 12/31/2015	66578	Contracts
						11/18/2015 12/29/2015		
	963	MINNESOTA STATE AUDITOR			7,647.18	1 Transactions		
41		DEPT Total:			7,647.18	COUNTY AUDITOR-TREASURER'S	1 Vendors	1 Transactions
111		DEPT				COURTHOUSE BUILDING		
	4147	WEST CENTRAL SANITATION INC						
102		01-111-000-0000-6257	AP	4	238.42	8 YEARD ROLL SERIVCE	10486534	Sewer, Water And Garbage
	4147	WEST CENTRAL SANITATION INC			238.42	1 Transactions		
111		DEPT Total:			238.42	COURTHOUSE BUILDING	1 Vendors	1 Transactions
116		DEPT				HEALTH AND HUMAN SERVICES BUILDII		
	4147	WEST CENTRAL SANITATION INC						
101		01-116-000-0000-6257	AP	4	171.17	2 YEAR ROLL SERVICE	1486532	Sewer, Water And Garbage Removal
	4147	WEST CENTRAL SANITATION INC			171.17	1 Transactions		
116		DEPT Total:			171.17	HEALTH AND HUMAN SERVICES BUILI	1 Vendors	1 Transactions
117		DEPT				FAIRGROUNDS		
	4147	WEST CENTRAL SANITATION INC						
93		01-117-000-0000-6257	AP	4	446.27	CONTRACTED SERVICE	10486531	Sewer, Water And Garbage Removal
						12/01/2015 12/31/2015		
	4147	WEST CENTRAL SANITATION INC			446.27	1 Transactions		
117		DEPT Total:			446.27	FAIRGROUNDS	1 Vendors	1 Transactions
201		DEPT				COUNTY SHERIFF'S OFFICE		
	4724	COUNTY OF ANOKA HUMAN SERVICES						
1		01-201-000-0000-6369			20,596.00	1ST QTR 2016 SERVICES		MEDICAL EXAMINER
	4724	COUNTY OF ANOKA HUMAN SERVICES			20,596.00	1 Transactions		

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
	1160	MCLEOD COUNTY AUDITOR TREASUREF					
37		01-201-000-0000-6327		12.00	#160 LICENSE PLATE FEE		General Auto Maintenance
38		01-201-000-0000-6327		12.00	#148 LICENSE PLATE FEE		General Auto Maintenance
39		01-201-000-0000-6327		12.00	#157 LICENSE PLATE FEE		General Auto Maintenance
40		01-201-000-0000-6327		12.00	#135 LICENSE PLATE FEE		General Auto Maintenance
41		01-201-000-0000-6327		12.00	#121 LICENSE PLATE FEE		General Auto Maintenance
42		01-201-000-0000-6327		16.00	#35 LICENSE PLATE FEE		General Auto Maintenance
43		01-201-000-0000-6327		16.00	#993 LICENSE PLATE FEE		General Auto Maintenance
	1160	MCLEOD COUNTY AUDITOR TREASUREF		92.00	7 Transactions		
201	DEPT Total:			20,688.00	COUNTY SHERIFF'S OFFICE	2 Vendors	8 Transactions
485	DEPT				COUNTY PUBLIC HEALTH NURSING		
	277	GOVERNMENT TRAINING SERVICE					
89		01-485-000-0000-6245		325.00	REGISTRATION GOVENOR'S HSEM		Dues And Registration Fees
	277	GOVERNMENT TRAINING SERVICE		325.00	1 Transactions		
485	DEPT Total:			325.00	COUNTY PUBLIC HEALTH NURSING	1 Vendors	1 Transactions
1	Fund Total:			42,937.80	GENERAL REVENUE FUND		55 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
0		DEPT				...		
	1241	MADISON NATIONAL LIFE INSURANCE C						
30		03-000-000-0000-2041			153.72	STD PREMIUM HIGHWAY FUND		Short Term Disability Payable
						01/01/2016 01/31/2016		
21		03-000-000-0000-2050			153.30	LTD PREMIUM HIGHWAY FUND		Long Term Disability Payable
						01/01/2016 01/31/2016		
	1241	MADISON NATIONAL LIFE INSURANCE C			307.02	2 Transactions		
	1360	MINNESOTA MUTUAL						
62		03-000-000-0000-2049			419.92	LIFE PREMIUM HIGHWAY FUND		Life Insurance Payable
						01/01/2016 01/31/2016		
	1360	MINNESOTA MUTUAL			419.92	1 Transactions		
0		DEPT Total:			726.94	...	2 Vendors	3 Transactions
320		DEPT				HIGHWAY CONSTRUCTION		
	5469	STONEBROOKE ENGINEERING INC						
91		03-320-000-0000-6641	AP	4	639.57	ROUNDABOUT CONST ENG 1152	333.24	State Aid-Regular Construction
90		03-320-000-0000-6647	AP	4	1,001.20	MILL & OVERLAY CONST ENG 1152	333.24	Joint Road Projects
	5469	STONEBROOKE ENGINEERING INC			1,640.77	2 Transactions		
320		DEPT Total:			1,640.77	HIGHWAY CONSTRUCTION	1 Vendors	2 Transactions
340		DEPT				HIGHWAY EQUIPMENT MAINTENANCE		
	5527	TOWMASTER INC						
92		03-340-000-0000-6610	AP	4	16,701.00	F550 EQUIPMENT PACKAGE	376642	Capital - Over $5,000 (Fixed Assets)
	5527	TOWMASTER INC			16,701.00	1 Transactions		
340		DEPT Total:			16,701.00	HIGHWAY EQUIPMENT MAINTENANCE	1 Vendors	1 Transactions
3		Fund Total:			19,068.71	ROAD & BRIDGE FUND		6 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
391	DEPT				SOLID WASTE TIP FEE		
	664	LENTSCH TRUCKING					
98		05-391-000-0000-6269		80.00	PAPER DRIVE		Contracts
	664	LENTSCH TRUCKING		80.00	1 Transactions		
	1241	MADISON NATIONAL LIFE INSURANCE C					
31		05-391-000-0000-2041		22.04	STD PREMIUM SW FUND		Short Term Disability Payable
					01/01/2016 01/31/2016		
22		05-391-000-0000-2050		25.52	LTD PREMIUM SW FUND		Long Term Disability Payable
					01/01/2016 01/31/2016		
	1241	MADISON NATIONAL LIFE INSURANCE C		47.56	2 Transactions		
	1360	MINNESOTA MUTUAL					
63		05-391-000-0000-2049		94.50	LIFE PREMIUM SW FUND		Life Insurance Payable
					01/01/2016 01/31/2016		
	1360	MINNESOTA MUTUAL		94.50	1 Transactions		
391	DEPT Total:			222.06	SOLID WASTE TIP FEE	3 Vendors	4 Transactions
393	DEPT				MATERIALS RECOVERY FACILITY		
	664	LENTSCH TRUCKING					
97		05-393-000-0000-6269		3,870.00	RECYCLED MATL SHIPPING		Contracts
	664	LENTSCH TRUCKING		3,870.00	1 Transactions		
	1241	MADISON NATIONAL LIFE INSURANCE C					
32		05-393-000-0000-2041		26.00	STD PREMIUM MRF FUND		Short Term Disability Payable
					01/01/2016 01/31/2016		
23		05-393-000-0000-2050		20.14	LTD PREMIUM MRF FUND		Long Term Disability Payable
					01/01/2016 01/31/2016		
	1241	MADISON NATIONAL LIFE INSURANCE C		46.14	2 Transactions		
	1360	MINNESOTA MUTUAL					
64		05-393-000-0000-2049		92.92	LIFE PREMIUM MRF FUND		Life Insurance Payable
					01/01/2016 01/31/2016		
	1360	MINNESOTA MUTUAL		92.92	1 Transactions		
	4170	WASTE MANAGEMENT OF WI MN					
100		05-393-000-0000-6257		876.39	GLASS FIND DISPOSAL	12981-1702-7	Sewer, Water And Garbage Removal

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
	4170	WASTE MANAGEMENT OF WI MN		876.39	1 Transactions		
393		DEPT Total:		4,885.45	MATERIALS RECOVERY FACILITY	4 Vendors	5 Transactions
397		DEPT			HOUSEHOLD HAZARDOUS WASTE		
	664	LENTSCH TRUCKING					
96		05-397-000-0000-6269		100.00	RECYCLABLES PICKED UP		Contracts
	664	LENTSCH TRUCKING		100.00	1 Transactions		
	1241	MADISON NATIONAL LIFE INSURANCE C					
33		05-397-000-0000-2041		37.92	STD PREMIUM HHW FUND 01/01/2016 01/31/2016		Short Term Disability Payable
24		05-397-000-0000-2050		22.60	LTD PREMIUM HHW FUND 01/01/2016 01/31/2016		Long Term Disability Payable
	1241	MADISON NATIONAL LIFE INSURANCE C		60.52	2 Transactions		
	1360	MINNESOTA MUTUAL					
65		05-397-000-0000-2049		21.91	LIFE PREMIUM HHW FUND 01/01/2016 01/31/2016		Life Insurance Payable
	1360	MINNESOTA MUTUAL		21.91	1 Transactions		
397		DEPT Total:		182.43	HOUSEHOLD HAZARDOUS WASTE	3 Vendors	4 Transactions
5		Fund Total:		5,289.94	SOLID WASTE FUND		13 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
420	DEPT				INCOME MAINTENANCE		
	1241	MADISON NATIONAL LIFE INSURANCE C					
34		11-420-000-0000-2041		198.69	STD PREMIUM INC MAINT FUND 01/01/2016 01/31/2016		Short Term Disability Payable
25		11-420-000-0000-2050		110.21	LTD PREMIUM INC MAINT FUND 01/01/2016 01/31/2016		Long Term Disability Payable
	1241	MADISON NATIONAL LIFE INSURANCE C		308.90	2 Transactions		
	1360	MINNESOTA MUTUAL					
66		11-420-000-0000-2049		456.95	LIFE PREMIUM INC MAINT FUND 01/01/2016 01/31/2016		Life Insurance Payable
	1360	MINNESOTA MUTUAL		456.95	1 Transactions		
420	DEPT Total:			765.85	INCOME MAINTENANCE	2 Vendors	3 Transactions
430	DEPT				INDIVIDUAL AND FAMILY SOCIAL SERVI		
	1241	MADISON NATIONAL LIFE INSURANCE C					
35		11-430-000-0000-2041		1,024.85	STD PREMIUM WELFARE FUND 01/01/2016 01/31/2016		Short Term Disability Payable
26		11-430-000-0000-2050		493.80	LTD PREMIUM WELFARE FUND 01/01/2016 01/31/2016		Long Term Disability Payable
	1241	MADISON NATIONAL LIFE INSURANCE C		1,518.65	2 Transactions		
	1360	MINNESOTA MUTUAL					
67		11-430-000-0000-2049		1,599.04	LIFE PREMIUM WELFARE FUND 01/01/2016 01/31/2016		Life Insurance Payable
	1360	MINNESOTA MUTUAL		1,599.04	1 Transactions		
430	DEPT Total:			3,117.69	INDIVIDUAL AND FAMILY SOCIAL SER	2 Vendors	3 Transactions
11	Fund Total:			3,883.54	HUMAN SERVICE FUND		6 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
633	DEPT			COUNTY DITCH #20		
2042	HJERPE CONTRACTING INC					
95	20-633-000-0000-6302		72,740.93	PAYMENT # 3		Construction And Repairs
2042	HJERPE CONTRACTING INC		72,740.93	1 Transactions		
9825	SHORT ELLIOTT HENDRICKSON INC					
99	20-633-000-0000-6302		752.00	ENGINEERING WORK CD #20	308860	Construction And Repairs
9825	SHORT ELLIOTT HENDRICKSON INC		752.00	1 Transactions		
633	DEPT Total:		73,492.93	COUNTY DITCH #20	2 Vendors	2 Transactions
682	DEPT			JOINT DITCH #24 SMCR		
2881	SK TRUCKING & EXCAVATING					
78	20-682-000-0000-6302		2,645.25	JD 24 SMCR TILE OULETS REPAIR	351	Construction And Repairs
2881	SK TRUCKING & EXCAVATING		2,645.25	1 Transactions		
682	DEPT Total:		2,645.25	JOINT DITCH #24 SMCR	1 Vendors	1 Transactions
20	Fund Total:		76,138.18	COUNTY DITCH FUND		3 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
15	DEPT					LAW LIBRARY		
	358	WEST PAYMENT CENTER						
84		25-015-000-0000-6451	AP	4	125.00	WEST INFORMATION CHARGES	833206618	Books
						12/01/2015 12/31/2015		
	358	WEST PAYMENT CENTER			125.00	1 Transactions		
15	DEPT Total:				125.00	LAW LIBRARY	1 Vendors	1 Transactions
220	DEPT					BOAT & WATER SAFETY-GRANT		
	1360	MINNESOTA MUTUAL						
68		25-220-000-0000-2049			0.07	LIFE PREMIUM BOAT & WATER FUND		Life Insurance Payable
						01/01/2016 01/31/2016		
	1360	MINNESOTA MUTUAL			0.07	1 Transactions		
220	DEPT Total:				0.07	BOAT & WATER SAFETY-GRANT	1 Vendors	1 Transactions
223	DEPT					D.A.R.E. PROGRAM		
	6257	CREATIVE PRODUCT SOURCING INC DAI						
87		25-223-000-0000-6350			223.54	DARE SUPPLIES	79795	Other Services & Charges
	6257	CREATIVE PRODUCT SOURCING INC DAI			223.54	1 Transactions		
223	DEPT Total:				223.54	D.A.R.E. PROGRAM	1 Vendors	1 Transactions
225	DEPT					MCLEOD COUNTY SHERIFFS POSSE		
	1360	MINNESOTA MUTUAL						
69		25-225-000-0000-2049			0.49	LIFE PREMIUM POSSE FUND		Life Insurance Payable
						01/01/2016 01/31/2016		
	1360	MINNESOTA MUTUAL			0.49	1 Transactions		
225	DEPT Total:				0.49	MCLEOD COUNTY SHERIFFS POSSE	1 Vendors	1 Transactions
252	DEPT					JAIL CANTEEN ACCOUNT		
	6195	GOOD HOUSEKEEPING						
88		25-252-000-0000-6450			20.00	2 YEAR SUBSCRIPTION		Subscriptions
	6195	GOOD HOUSEKEEPING			20.00	1 Transactions		
	1922	WOMANS DAY						

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
85	25-252-000-0000-6450		9.99	1 YEAR SUBSCRIPTION		Subscriptions
1922	WOMANS DAY		9.99	1 Transactions		
252	DEPT Total:		29.99	JAIL CANTEEN ACCOUNT	2 Vendors	2 Transactions
485	DEPT			COUNTY PUBLIC HEALTH NURSING		
1241	MADISON NATIONAL LIFE INSURANCE C					
27	25-485-000-0000-2050		11.28	LTD PREMIUM PRIME WEST FUND		LONG TERM DISABILITY PAYABLE
				01/01/2016 01/31/2016		
1241	MADISON NATIONAL LIFE INSURANCE C		11.28	1 Transactions		
1360	MINNESOTA MUTUAL					
70	25-485-000-0000-2049		8.19	LIFE PREMIUM PRIME WEST FUND		LIFE INSURANCE PAYABLE
				01/01/2016 01/31/2016		
1360	MINNESOTA MUTUAL		8.19	1 Transactions		
485	DEPT Total:		19.47	COUNTY PUBLIC HEALTH NURSING	2 Vendors	2 Transactions
612	DEPT			SHORELAND-GRANT		
1360	MINNESOTA MUTUAL					
71	25-612-000-0000-2049		5.82	LIFE PREMIUM SHORELAND FUND		Life Insurance Payable
				01/01/2016 01/31/2016		
1360	MINNESOTA MUTUAL		5.82	1 Transactions		
612	DEPT Total:		5.82	SHORELAND-GRANT	1 Vendors	1 Transactions
613	DEPT			WATER RESOURCE MANAGEMENT-GRA		
1360	MINNESOTA MUTUAL					
72	25-613-000-0000-2049		9.49	LIFE PREMIUM WATER RESOURCE		Life Insurance Payable
				01/01/2016 01/31/2016		
1360	MINNESOTA MUTUAL		9.49	1 Transactions		
613	DEPT Total:		9.49	WATER RESOURCE MANAGEMENT-GR	1 Vendors	1 Transactions
614	DEPT			WETLANDS ADMINISTRATION-GRANT		
1360	MINNESOTA MUTUAL					
73	25-614-000-0000-2049		22.12	LIFE PREMIUM WETLANDS FUND		Life Insurance Payable
				01/01/2016 01/31/2016		

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
1360	MINNESOTA MUTUAL		22.12	1 Transactions		
614	DEPT Total:		22.12	WETLANDS ADMINISTRATION-GRANT	1 Vendors	1 Transactions
886	DEPT			COUNTY FEEDLOT PROGRAM		
1360	MINNESOTA MUTUAL					
74	25-886-000-0000-2049		29.22	LIFE PREMIUM FEEDLOT FUND 01/01/2016 01/31/2016		Life Insurance Payable
1360	MINNESOTA MUTUAL		29.22	1 Transactions		
886	DEPT Total:		29.22	COUNTY FEEDLOT PROGRAM	1 Vendors	1 Transactions
25	Fund Total:		465.21	SPECIAL REVENUE FUND		12 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
853	DEPT			LOCAL PUBLIC HEALTH GRANT		
1241	MADISON NATIONAL LIFE INSURANCE C					
36	82-853-000-0000-2041		26.80	STD PREMIUM SHNFP FUND 01/01/2016 01/31/2016		SHORT TERM DISABILITY PAYABLE
28	82-853-000-0000-2050		11.90	LTD PREMIUM CHS FUND 01/01/2016 01/31/2016		LONG TERM DISABILITY PAYABLE
1241	MADISON NATIONAL LIFE INSURANCE C		38.70	2 Transactions		
1360	MINNESOTA MUTUAL					
75	82-853-000-0000-2049		102.43	LIFE PREMIUM CHS FUND 01/01/2016 01/31/2016		LIFE INSURANCE PAYABLE
1360	MINNESOTA MUTUAL		102.43	1 Transactions		
853	DEPT Total:		141.13	LOCAL PUBLIC HEALTH GRANT	2 Vendors	3 Transactions
862	DEPT			SHIP		
5576	BACHMAN/MARY					
86	82-862-000-0000-6121		980.00	SHIP GRANT TIME		Personnel Wages
5576	BACHMAN/MARY		980.00	1 Transactions		
862	DEPT Total:		980.00	SHIP	1 Vendors	1 Transactions
82	Fund Total:		1,121.13	COMMUNITY HEALTH SERVICE		4 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
975	DEPT			DNR CLEARING ACCOUNT		
	509 MINNESOTA DNR					
60	86-975-000-0000-6850		1,821.50	DNR		Collections For Other Agencies
				01/20/2016 01/25/2016		
	509 MINNESOTA DNR		1,821.50	1 Transactions		
975	DEPT Total:		1,821.50	DNR CLEARING ACCOUNT	1 Vendors	1 Transactions
976	DEPT			GAME & FISH CLEARING ACCOUNT		
	509 MINNESOTA DNR					
59	86-976-000-0000-6850		42.00	G & F		Collections For Other Agencies
				01/20/2016 01/25/2016		
	509 MINNESOTA DNR		42.00	1 Transactions		
976	DEPT Total:		42.00	GAME & FISH CLEARING ACCOUNT	1 Vendors	1 Transactions
86	Fund Total:		1,863.50	TRUST & AGENCY FUND		2 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
980	DEPT				TAX COLLECTIONS		
492	SCHOOL DISTRICT OF HLWW 2687						
79	87-980-000-0000-6849	DTG	6	11,653.64	DECEMBER CURRENT SETTLEMENT		Collections For School Districts
80	87-980-000-0000-6849	DTG	6	562.65	DECEMBER DELINQUENT SETTLEMENT		Collections For School Districts
492	SCHOOL DISTRICT OF HLWW 2687			12,216.29	2 Transactions		
980	DEPT Total:			12,216.29	TAX COLLECTIONS	1 Vendors	2 Transactions
87	Fund Total:			12,216.29	TAX & PENALTY FUND		2 Transactions
	Final Total:			162,984.30	54 Vendors	103 Transactions	

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Recap by Fund

Fund	AMOUNT	Name
1	42,937.80	GENERAL REVENUE FUND
3	19,068.71	ROAD & BRIDGE FUND
5	5,289.94	SOLID WASTE FUND
11	3,883.54	HUMAN SERVICE FUND
20	76,138.18	COUNTY DITCH FUND
25	465.21	SPECIAL REVENUE FUND
82	1,121.13	COMMUNITY HEALTH SERVICE
86	1,863.50	TRUST & AGENCY FUND
87	12,216.29	TAX & PENALTY FUND
All Funds	162,984.30	Total

Approved by, ...

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********* McLeod County IFS *********

Audit List for Board AUDITOR'S VOUCHERS ENTRIES

Print List in Order By: 2

1 - Fund (Page Break by Fund)
2 - Department (Totals by Dept)
3 - Vendor Number
4 - Vendor Name

Page Break By: 1

1 - Page Break by Fund
2 - Page Break by Dept

Explode Dist. Formulas Y

Paid on Behalf Of Name on Audit List?: N

Type of Audit List: D

D - Detailed Audit List
S - Condensed Audit List

Save Report Options?: N

Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
5	DEPT			BOARD OF COUNTY COMMISSIONERS		
	1886 BMO					
36	01-005-000-0000-6245		515.00	NACO	1627	Dues And Registration Fees
	1886 BMO		515.00	1 Transactions		
5	DEPT Total:		515.00	BOARD OF COUNTY COMMISSIONERS	1 Vendors	1 Transactions
31	DEPT			COUNTY ADMINISTRATOR'S		
	1886 BMO					
37	01-031-000-0000-6402		32.39	WORDSANYWHERE	1627	Office Supplies
38	01-031-000-0000-6810		42.54	SUBWAY	1627	REFUNDS AND REIMBURSEMENTS
	1886 BMO		74.93	2 Transactions		
31	DEPT Total:		74.93	COUNTY ADMINISTRATOR'S	1 Vendors	2 Transactions
76	DEPT			CENTRAL SERVICES-COUNTY WIDE		
	1886 BMO					
1	01-076-000-0000-6205		147.55	USPS	9909	Postage And Postal Box Rental
	1886 BMO		147.55	1 Transactions		
76	DEPT Total:		147.55	CENTRAL SERVICES-COUNTY WIDE	1 Vendors	1 Transactions
91	DEPT			COUNTY ATTORNEY'S		
	1886 BMO					
83	01-091-000-0000-6245		200.00	USDC MN	1155	Dues And Registration Fees
84	01-091-000-0000-6402		16.32	AMAZON	1155	Office Supplies
	1886 BMO		216.32	2 Transactions		
91	DEPT Total:		216.32	COUNTY ATTORNEY'S	1 Vendors	2 Transactions
101	DEPT			COUNTY RECORDER'S		
	1886 BMO					
42	01-101-000-0000-6402		50.57	WW GRAINGER	1650	Office Supplies
2	01-101-000-0000-6245		285.00	MACO	9909	Dues And Registration Fees
	1886 BMO		335.57	2 Transactions		

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
101	DEPT Total:		335.57	COUNTY RECORDER'S	1 Vendors	2 Transactions
103	DEPT			COUNTY ASSESSOR'S		
1886	BMO					
3	01-103-000-0000-6450		22.86	BEEN VERIFIED	9891	Subscriptions
1886	BMO		22.86	1 Transactions		
103	DEPT Total:		22.86	COUNTY ASSESSOR'S	1 Vendors	1 Transactions
116	DEPT			HEALTH AND HUMAN SERVICES BUILDII		
1886	BMO					
41	01-116-000-0000-6425		82.20	AMERICAN FILTRATION CORP	1650	Repair And Maintenance Supplies
1886	BMO		82.20	1 Transactions		
116	DEPT Total:		82.20	HEALTH AND HUMAN SERVICES BUILI	1 Vendors	1 Transactions
201	DEPT			COUNTY SHERIFF'S OFFICE		
1886	BMO					
49	01-201-000-0000-6402		38.18	AMAZON	1585	Office Supplies
48	01-201-000-0000-6456		200.00	MI MIDWEST INDUSTRIES	1585	Shooting Supplies For Firearms Program
50	01-201-206-0000-6360		250.00	GLOCK PROFESSIONAL INC	1585	Training - Patrol
39	01-201-000-0000-6402		47.74	HITT MARKING DEVICES	1650	Office Supplies
40	01-201-000-0000-6402		58.05	STAMP COLLECTION	1650	Office Supplies
1886	BMO		593.97	5 Transactions		
201	DEPT Total:		593.97	COUNTY SHERIFF'S OFFICE	1 Vendors	5 Transactions
251	DEPT			COUNTY JAIL		
1886	BMO					
66	01-251-000-0000-6360		134.00	SKILLPATH	1528	Training
67	01-251-000-0000-6360		134.00	SKILLPATH	1528	Training
68	01-251-000-0000-6360		134.00	SKILLPATH	1528	Training
75	01-251-000-0000-6415		40.99	AMAZON	1528	Cleaning Supplies
76	01-251-000-0000-6460		27.65	AMAZON	1528	Jail Supplies
1886	BMO		470.64	5 Transactions		

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Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
251	DEPT Total:			470.64	COUNTY JAIL	1 Vendors	5 Transactions
281	DEPT				EMERGENCY MANAGEMENT		
	1886 BMO						
51	01-281-000-0000-6402			40.44	AMAZON	1585	Office Supplies
47	01-281-000-0000-6610	AP	4	487.30	OTTOR PRODUCTS LLC	1585	Capital - Over $5,000 (Fixed Assets)
	1886 BMO			527.74	2 Transactions		
281	DEPT Total:			527.74	EMERGENCY MANAGEMENT	1 Vendors	2 Transactions
485	DEPT				COUNTY PUBLIC HEALTH NURSING		
	1886 BMO						
4	01-485-000-0000-6245			340.00	FRED PRYOR	9556	Dues And Registration Fees
6	01-485-000-0000-6364			1.99	COBORNS	9556	County Employee Wellness Committee
7	01-485-000-0000-6336			287.24	RAMADA	9564	Meals, Lodging, Parking & Miscellaneous
8	01-485-000-0000-6336			220.75	ECONOMY INN	9564	Meals, Lodging, Parking & Miscellaneous
10	01-485-000-0000-6336			85.34	MOLLYS CAFE	9564	Meals, Lodging, Parking & Miscellaneous
	1886 BMO			935.32	5 Transactions		
485	DEPT Total:			935.32	COUNTY PUBLIC HEALTH NURSING	1 Vendors	5 Transactions
609	DEPT				ENVIRONMENTAL SERVICES		
	1886 BMO						
43	01-609-000-0000-6245			49.00	FRED PRYOR SEMINARS	0963	Dues And Registration Fees
	1886 BMO			49.00	1 Transactions		
609	DEPT Total:			49.00	ENVIRONMENTAL SERVICES	1 Vendors	1 Transactions
615	DEPT				ISTS COMMITTEE		
	1886 BMO						
44	01-615-000-0000-6245			295.00	MOWA MN ONSITE	0963	Dues And Registration Fees
45	01-615-000-0000-6245			295.00	MOWA MN ONSITE	0963	Dues And Registration Fees
46	01-615-000-0000-6245			265.00	U OF M CONTINUING LEARNING	0963	Dues And Registration Fees
	1886 BMO			855.00	3 Transactions		
615	DEPT Total:			855.00	ISTS COMMITTEE	1 Vendors	3 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
1	Fund Total:		4,826.10	GENERAL REVENUE FUND		31 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
330	DEPT			HIGHWAY ADMINISTRATION		
1886	BMO					
11	03-330-000-0000-6205		49.00	USPS	9937	Postage And Postal Box Rental
12	03-330-000-0000-6205		9.79	USPS	9937	Postage And Postal Box Rental
13	03-330-000-0000-6205		4.85	USPS	9937	Postage And Postal Box Rental
14	03-330-000-0000-6205		13.14	USPS	9937	Postage And Postal Box Rental
16	03-330-000-0000-6245		575.00	ARM OF MN	9937	Dues And Registration Fees
15	03-330-000-0000-6402		70.97	AMAZON.COM	9937	Office Supplies
1886	BMO		722.75	6 Transactions		
330	DEPT Total:		722.75	HIGHWAY ADMINISTRATION	1 Vendors	6 Transactions
340	DEPT			HIGHWAY EQUIPMENT MAINTENANCE		
1886	BMO					
17	03-340-000-0000-6590		84.50	MN STATE PATROL	9945	Tools & Shop Materials
1886	BMO		84.50	1 Transactions		
340	DEPT Total:		84.50	HIGHWAY EQUIPMENT MAINTENANCE	1 Vendors	1 Transactions
3	Fund Total:		807.25	ROAD & BRIDGE FUND		7 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
391	DEPT			SOLID WASTE TIP FEE		
1886	BMO					
56	05-391-000-0000-6243		111.07	JOANN FABRIC	1550	Public Education
57	05-391-000-0000-6243		44.56	JOANN FABRIC	1550	Public Education
58	05-391-000-0000-6243		84.36	JOANN FABRIC	1550	Public Education
59	05-391-000-0000-6243		39.12	TARGET	1550	Public Education
55	05-391-000-0000-6410		128.60	AMAZON	1550	Building And Safety Supplies
1886	BMO		407.71	5 Transactions		
391	DEPT Total:		407.71	SOLID WASTE TIP FEE	1 Vendors	5 Transactions
5	Fund Total:		407.71	SOLID WASTE FUND		5 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
430	DEPT			INDIVIDUAL AND FAMILY SOCIAL SERVI		
1886	BMO					
31	11-430-709-0008-6359		31.38	SHOPKO	0930	CWTCM Dedicated
28	11-430-710-1160-6040		100.00	CASEYS	0930	Social Service Transportation
29	11-430-710-1160-6040		100.00	CASEYS	0930	Social Service Transportation
30	11-430-710-1160-6040		100.00	COBORNS	0930	Social Service Transportation
32	11-430-710-1160-6040		180.00	METRO TRASNSIT	0930	Social Service Transportation
18	11-430-709-0200-6098		199.59	WALMART	0948	Other Social Services
19	11-430-741-4030-6071		333.75	JOANN FABRIC	0948	Client Outreach - CSP
20	11-430-741-4030-6071		37.50	STATE THEATRE	0948	Client Outreach - CSP
21	11-430-741-4030-6071		8.52	JET.COM	0948	Client Outreach - CSP
22	11-430-741-4030-6071		16.39	JET.COM	0948	Client Outreach - CSP
23	11-430-741-4030-6071		50.65	SIMPLY JANE	0948	Client Outreach - CSP
24	11-430-741-4030-6071		22.58	SAMS CLUB	0948	Client Outreach - CSP
25	11-430-741-4030-6071		51.56	WALMART	0948	Client Outreach - CSP
26	11-430-741-4030-6071		18.47	CRAFTS DIRECT	0948	Client Outreach - CSP
27	11-430-741-4030-6071		22.07	MENARDS	0948	Client Outreach - CSP
33	11-430-709-0000-6033		59.00	SOCIAL SERVICE.COM	9531	Mental Hlth Pilot Project-Discretionary
34	11-430-709-0000-6033		99.95	SOCIALWORKJOBBANK.COM	9531	Mental Hlth Pilot Project-Discretionary
35	11-430-709-0000-6033		99.00	SIMPLY HIRED.COM	9531	Mental Hlth Pilot Project-Discretionary
1886	BMO		1,530.41	18 Transactions		
430	DEPT Total:		1,530.41	INDIVIDUAL AND FAMILY SOCIAL SER	1 Vendors	18 Transactions
11	Fund Total:		1,530.41	HUMAN SERVICE FUND		18 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
205	DEPT			CARRY CONCEAL PERMIT		
1886	BMO					
52	25-205-000-0000-6350		123.00	AMAZON	1585	Other Services & Charges
1886	BMO		123.00	1 Transactions		
205	DEPT Total:		123.00	CARRY CONCEAL PERMIT	1 Vendors	1 Transactions
223	DEPT			D.A.R.E. PROGRAM		
1886	BMO					
54	25-223-000-0000-6350		162.30	CASH WISE	1593	Other Services & Charges
1886	BMO		162.30	1 Transactions		
223	DEPT Total:		162.30	D.A.R.E. PROGRAM	1 Vendors	1 Transactions
224	DEPT			NEW CANINE ACCOUNT		
1886	BMO					
53	25-224-000-0000-6350		288.93	RAY ALLEN MANUFACTURING	1601	OTHER SERVICES & CHARGES
1886	BMO		288.93	1 Transactions		
224	DEPT Total:		288.93	NEW CANINE ACCOUNT	1 Vendors	1 Transactions
252	DEPT			JAIL CANTEEN ACCOUNT		
1886	BMO					
74	25-252-000-0000-6460		59.90	AMAZON	1528	Jail Supplies
63	25-252-000-0000-6460		67.82	AMAZON	1528	Jail Supplies
64	25-252-000-0000-6460		18.99	AMAZON	1528	Jail Supplies
65	25-252-000-0000-6460		25.59	AMAZON	1528	Jail Supplies
69	25-252-000-0000-6460		10.99	AMAZON	1528	Jail Supplies
70	25-252-000-0000-6460		12.21	AMAZON	1528	Jail Supplies
71	25-252-000-0000-6460		65.37	AMAZON	1528	Jail Supplies
72	25-252-000-0000-6460		85.88	AMAZON	1528	Jail Supplies
73	25-252-000-0000-6460		40.65	AMAZON	1528	Jail Supplies
60	25-252-000-0000-6460		34.41	CASH WISE	1536	Jail Supplies
61	25-252-000-0000-6460		6.36	TARGET	1536	Jail Supplies
62	25-252-000-0000-6460		11.65	WALMART	1536	Jail Supplies
1886	BMO		439.82	12 Transactions		

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
252	DEPT Total:		439.82	JAIL CANTEEN ACCOUNT	1 Vendors	12 Transactions
25	Fund Total:		1,014.05	SPECIAL REVENUE FUND		15 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
852	DEPT			PROJECT HARMONY GRANT		
1886	BMO					
9	82-852-000-0000-6336		82.37	UNHINGED PIZZA	9564	Meals, Lodging, Parking & Miscellaneous
1886	BMO		82.37	1 Transactions		
852	DEPT Total:		82.37	PROJECT HARMONY GRANT	1 Vendors	1 Transactions
853	DEPT			LOCAL PUBLIC HEALTH GRANT		
1886	BMO					
77	82-853-000-0000-6336		13.42	BROADWAY BISTRO	0955	Meals, Lodging, Parking & Miscellaneous
78	82-853-000-0000-6336		19.59	DOOLITTLES	0955	Meals, Lodging, Parking & Miscellaneous
79	82-853-000-0000-6336		13.42	BROADWAY BISTRO	0955	Meals, Lodging, Parking & Miscellaneous
80	82-853-000-0000-6336		207.52	HAMPTONS INN	0955	Meals, Lodging, Parking & Miscellaneous
81	82-853-000-0000-6336		13.95	RAPPERS EATERY	0955	Meals, Lodging, Parking & Miscellaneous
5	82-853-000-0000-6336		18.48	COBORNS	9556	Meals, Lodging, Parking & Miscellaneous
1886	BMO		286.38	6 Transactions		
853	DEPT Total:		286.38	LOCAL PUBLIC HEALTH GRANT	1 Vendors	6 Transactions
862	DEPT			SHIP		
1886	BMO					
82	82-862-000-0000-6265		60.00	CONSTANT CONTACT	0955	Professional Services
1886	BMO		60.00	1 Transactions		
862	DEPT Total:		60.00	SHIP	1 Vendors	1 Transactions
82	Fund Total:		428.75	COMMUNITY HEALTH SERVICE		8 Transactions
	Final Total:		9,014.27	24 Vendors	84 Transactions	

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Recap by Fund

Fund	AMOUNT	Name
1	4,826.10	GENERAL REVENUE FUND
3	807.25	ROAD & BRIDGE FUND
5	407.71	SOLID WASTE FUND
11	1,530.41	HUMAN SERVICE FUND
25	1,014.05	SPECIAL REVENUE FUND
82	428.75	COMMUNITY HEALTH SERVICE
All Funds	9,014.27	Total

Approved by, ...

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Audit List for Board AUDITOR'S VOUCHERS ENTRIES

Print List in Order By: 2

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2 - Department (Totals by Dept)
3 - Vendor Number
4 - Vendor Name

Page Break By: 1

1 - Page Break by Fund
2 - Page Break by Dept

Explode Dist. Formulas Y

Paid on Behalf Of Name on Audit List?: N

Type of Audit List: D

D - Detailed Audit List
S - Condensed Audit List

Save Report Options?: N

Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
0	DEPT			...		
3028	MINNESOTA CHILD SUPPORT PAYMENT					
28	01-000-000-0000-2056		314.25	CHILD SUPPORT 01/10/2016 01/23/2016	001124208702	Child Support Garnishment Payable
30	01-000-000-0000-2056		114.90	CHILD SUPPORT 01/10/2016 01/23/2016	001436294701	Child Support Garnishment Payable
27	01-000-000-0000-2056		255.19	CHILD SUPPORT 01/10/2016 01/23/2016	001447664801	Child Support Garnishment Payable
34	01-000-000-0000-2056		850.80	CHILD SUPPORT JAYSON NEUBARTH	0014720624	Child Support Garnishment Payable
29	01-000-000-0000-2056		130.13	CHILD SUPPORT 01/10/2016 01/23/2016	001499730601	Child Support Garnishment Payable
31	01-000-000-0000-2056		148.59	CHILD SUPPORT 01/10/2016 01/23/2016	001527027301	Child Support Garnishment Payable
32	01-000-000-0000-2056		327.64	CHILD SUPPORT 01/10/2016 01/23/2016	001530953002	Child Support Garnishment Payable
3028	MINNESOTA CHILD SUPPORT PAYMENT		2,141.50	7 Transactions		
0	DEPT Total:		2,141.50	...	1 Vendors	7 Transactions
13	DEPT			COURT ADMINISTRATOR'S		
11580	CENTURYLINK					
6	01-013-000-0000-6203		37.87	LONG DISTANCE	320439462	Communications
11580	CENTURYLINK		37.87	1 Transactions		
5485	DOHERTY SCHOOLER/TIFFANY					
44	01-013-000-0000-6272		180.00	COURT APPOINT BR	JV-14-237	Court Appt Atty-Dep/Neg/Ter
43	01-013-000-0000-6272		502.50	COURT APPOINT JO/SB	JV-15-136	Court Appt Atty-Dep/Neg/Ter
42	01-013-000-0000-6272		495.00	COURT APPOINT PS/DP	JV-15-138	Court Appt Atty-Dep/Neg/Ter
41	01-013-000-0000-6272		345.00	COURT APPOINT JW/HW	JV-15-139	Court Appt Atty-Dep/Neg/Ter
5485	DOHERTY SCHOOLER/TIFFANY		1,522.50	4 Transactions		
3217	WACKER-HANJANI/JULIE					
50	01-013-000-0000-6273	AP 4	165.00	COURT APPOINT NR	FA-15-1265	Court Appt Atty-Other
51	01-013-000-0000-6273		131.25	COURT APPOINT NR	FA-15-1265	Court Appt Atty-Other
52	01-013-000-0000-6273	AP 4	11.25	COURT APPOINT AW	FA-15-1867	Court Appt Atty-Other
53	01-013-000-0000-6273		165.00	COURT APPOINT AW	FA-15-1867	Court Appt Atty-Other
3217	WACKER-HANJANI/JULIE		472.50	4 Transactions		

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
13		DEPT Total:		2,032.87	COURT ADMINISTRATOR'S	3 Vendors	9 Transactions
75		DEPT			CENTRAL SERVICES-CHARGE BACKS		
	1160	MCLEOD COUNTY AUDITOR TREASUREF					
15		01-075-000-0000-6338		11.00	DUPLICATE REG 2010 ESCAPE		Motor Pool Expenses
	1160	MCLEOD COUNTY AUDITOR TREASUREF		11.00	1 Transactions		
	1083	WEX BANK					
24		01-075-000-0000-6338		987.02	FUEL MOTOR POOL	43877018	Motor Pool Expenses
					01/01/2016 01/31/2016		
	1083	WEX BANK		987.02	1 Transactions		
75		DEPT Total:		998.02	CENTRAL SERVICES-CHARGE BACKS	2 Vendors	2 Transactions
76		DEPT			CENTRAL SERVICES-COUNTY WIDE		
	5918	CENTURY LINK					
4		01-076-000-0000-6203		55.78	CIRCUIT CHARGE	66XCD6S16015	Communications
	5918	CENTURY LINK		55.78	1 Transactions		
	5906	CENTURYLINK					
3		01-076-000-0000-6203		307.47	LOCAL SVC	313623769	Communications
2		01-076-000-0000-6203		3,069.84	LOCAL SVC	314019358	Communications
	5906	CENTURYLINK		3,377.31	2 Transactions		
	11580	CENTURYLINK					
5		01-076-000-0000-6203		548.20	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		548.20	1 Transactions		
	5771	NU-TELECOM					
19		01-076-000-0000-6203		1,484.61	EXT PRI SW B1	81670181	Communications
	5771	NU-TELECOM		1,484.61	1 Transactions		
76		DEPT Total:		5,465.90	CENTRAL SERVICES-COUNTY WIDE	4 Vendors	5 Transactions
101		DEPT			COUNTY RECORDER'S		
	3151	GUARANTY BANK					
68		01-101-000-0000-6810		46.00	VOIDED DOC		Refunds And Reimbursements

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
	3151	GUARANTY BANK		46.00	1 Transactions		
101	DEPT Total:			46.00	COUNTY RECORDER'S	1 Vendors	1 Transactions
201	DEPT				COUNTY SHERIFF'S OFFICE		
	5906	CENTURYLINK					
40		01-201-000-0000-6203		47.86	PHONE CHARGES	313138411	Communications
					01/18/2016 02/17/2016		
	5906	CENTURYLINK		47.86	1 Transactions		
	11580	CENTURYLINK					
7		01-201-000-0000-6203		57.48	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		57.48	1 Transactions		
	5771	NU-TELECOM					
47		01-201-000-0000-6203		143.68	111-2290 SPEC ACC VOICE	81669992	Communications
					02/01/2016 02/29/2016		
	5771	NU-TELECOM		143.68	1 Transactions		
201	DEPT Total:			249.02	COUNTY SHERIFF'S OFFICE	3 Vendors	3 Transactions
485	DEPT				COUNTY PUBLIC HEALTH NURSING		
	11580	CENTURYLINK					
8		01-485-000-0000-6203		70.27	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		70.27	1 Transactions		
485	DEPT Total:			70.27	COUNTY PUBLIC HEALTH NURSING	1 Vendors	1 Transactions
520	DEPT				COUNTY PARK'S		
	5771	NU-TELECOM					
20		01-520-000-0000-6203		40.07	PIEPENBURG 587-2082	81670181	Communications
	5771	NU-TELECOM		40.07	1 Transactions		
520	DEPT Total:			40.07	COUNTY PARK'S	1 Vendors	1 Transactions
1	Fund Total:			11,043.65	GENERAL REVENUE FUND		29 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr		Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
320	DEPT				HIGHWAY CONSTRUCTION		
4685	KNIFE RIVER CORPORATION						
71	03-320-000-0000-6641	AP	4	95,000.00	PAYMENT #4 SAP 043-617-009	617-009-3	State Aid-Regular Construction
72	03-320-000-0000-6643	AP	4	19,187.58	PAYMENT #5 SAP 043-619-009	617-009-3	County Road Construction
70	03-320-000-0000-6643	AP	4	54,771.01	PAYMENT #5 SAP 043-626-005	626-005-3	County Road Construction
4685	KNIFE RIVER CORPORATION			168,958.59	3 Transactions		
5022	TRAFFIC MARKING SERVICE						
73	03-320-000-0000-6643	AP	4	774.10	PAYMENT #1 SP 043-070-009	070-009-1	County Road Construction
74	03-320-000-0000-6649	AP	4	6,966.88	PAYMENT #1 SP 043-070-009	070-009-11	FEDERAL SAFETY PROGRAMS
75	03-320-000-0000-6643	AP	4	310.98	PAYMENT # 1 SP 043-070-010	070-010-1	County Road Construction
76	03-320-000-0000-6649	AP	4	2,798.85	PAYMENT #1 SP 043-070-010	73-010-11	FEDERAL SAFETY PROGRAMS
5022	TRAFFIC MARKING SERVICE			10,850.81	4 Transactions		
320	DEPT Total:			179,809.40	HIGHWAY CONSTRUCTION	2 Vendors	7 Transactions
340	DEPT				HIGHWAY EQUIPMENT MAINTENANCE		
32875	HUTCHINSON UTILITIES COMMISSION						
25	03-340-000-0000-6253			107.89	ELECTRIC TEMP STORAGE	31021-045101	Electricity
26	03-340-000-0000-6255			376.54	GAS TEMP STORAGE	31021-045101	Natural Gas
32875	HUTCHINSON UTILITIES COMMISSION			484.43	2 Transactions		
1083	WEX BANK						
54	03-340-000-0000-6455			94.20	UNLEADED FUEL 01/01/2016 01/31/2016	43679892	Motor Fuels And Lubrication
55	03-340-000-0000-6455			23.84	UNLEADED FUEL 01/01/2016 01/31/2016	43679892	Motor Fuels And Lubrication
56	03-340-000-0000-6455			58.52	UNLEADED FUEL 01/01/2016 01/31/2016	43679892	Motor Fuels And Lubrication
57	03-340-000-0000-6455			59.62	UNLEADED FUEL 01/01/2016 01/31/2016	43679892	Motor Fuels And Lubrication
58	03-340-000-0000-6455			35.28	UNLEADED FUEL 01/01/2016 01/31/2016	43679892	Motor Fuels And Lubrication
66	03-340-000-0000-6455			27.96-	MISC PREV PER REBATE	43679892	Motor Fuels And Lubrication
59	03-340-000-0000-6567			8.77	DIESEL FUEL 01/01/2016 01/31/2016	43679892	Diesel Fuel & Tax
60	03-340-000-0000-6567			81.27	DIESEL FUEL 01/01/2016 01/31/2016	43679892	Diesel Fuel & Tax
61	03-340-000-0000-6567			42.10	DIESEL FUEL	43679892	Diesel Fuel & Tax

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
				01/01/2016 01/31/2016		
62	03-340-000-0000-6567		57.30	DIESEL FUEL	43679892	Diesel Fuel & Tax
				01/01/2016 01/31/2016		
63	03-340-000-0000-6567		392.17	DIESEL FUEL	43679892	Diesel Fuel & Tax
				01/01/2016 01/31/2016		
64	03-340-000-0000-6567		888.22	DIESEL FUEL	43679892	Diesel Fuel & Tax
				01/01/2016 01/31/2016		
65	03-340-000-0000-6567		576.79	DIESEL FUEL	43679892	Diesel Fuel & Tax
				01/01/2016 01/31/2016		
1083	WEX BANK		2,290.12	13 Transactions		
340	DEPT Total:		2,774.55	HIGHWAY EQUIPMENT MAINTENANCE	2 Vendors	15 Transactions
3	Fund Total:		182,583.95	ROAD & BRIDGE FUND		22 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
391		DEPT			SOLID WASTE TIP FEE		
	11580	CENTURYLINK					
9		05-391-000-0000-6203		8.50	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		8.50	1 Transactions		
391		DEPT Total:		8.50	SOLID WASTE TIP FEE	1 Vendors	1 Transactions
393		DEPT			MATERIALS RECOVERY FACILITY		
	340	ADULT TRAINING AND HABILITATION II					
1		05-393-000-0000-6269		19,250.00	WATERTOWN LEASE	151152	Contracts
	340	ADULT TRAINING AND HABILITATION II		19,250.00	1 Transactions		
	11580	CENTURYLINK					
10		05-393-000-0000-6203		7.29	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		7.29	1 Transactions		
393		DEPT Total:		19,257.29	MATERIALS RECOVERY FACILITY	2 Vendors	2 Transactions
397		DEPT			HOUSEHOLD HAZARDOUS WASTE		
	11580	CENTURYLINK					
11		05-397-000-0000-6203		2.46	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		2.46	1 Transactions		
397		DEPT Total:		2.46	HOUSEHOLD HAZARDOUS WASTE	1 Vendors	1 Transactions
5		Fund Total:		19,268.25	SOLID WASTE FUND		4 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
420	DEPT			INCOME MAINTENANCE		
11580	CENTURYLINK					
12	11-420-600-0010-6203		129.65	LONG DISTANCE	320439462	Communications/Postage
11580	CENTURYLINK		129.65	1 Transactions		
420	DEPT Total:		129.65	INCOME MAINTENANCE	1 Vendors	1 Transactions
430	DEPT			INDIVIDUAL AND FAMILY SOCIAL SERVI		
11580	CENTURYLINK					
13	11-430-700-0010-6203		302.30	LONG DISTANCE	320439462	Communications/Postage
11580	CENTURYLINK		302.30	1 Transactions		
3028	MINNESOTA CHILD SUPPORT PAYMENT					
33	11-430-000-0000-2056		276.88	CHILD SUPPORT	001486828601	Child Support Garnishment Payable
				01/10/2016 01/23/2016		
3028	MINNESOTA CHILD SUPPORT PAYMENT		276.88	1 Transactions		
430	DEPT Total:		579.18	INDIVIDUAL AND FAMILY SOCIAL SER	2 Vendors	2 Transactions
11	Fund Total:		708.83	HUMAN SERVICE FUND		3 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
252	DEPT				JAIL CANTEEN ACCOUNT		
	3510	BOB BARKER COMPANY INC					
36		25-252-000-0000-6460		49.98	HEAD & SHOULDERS	WEB000409765	Jail Supplies
	3510	BOB BARKER COMPANY INC		49.98	1 Transactions		
	5771	NU-TELECOM					
48		25-252-000-0000-6460		104.39	CABLE	81668876	Jail Supplies
					01/01/2016 01/29/2016		
	5771	NU-TELECOM		104.39	1 Transactions		
	2140	PHOENIX SUPPLY					
49		25-252-000-0000-6460		60.05	LOTION	8522	Jail Supplies
	2140	PHOENIX SUPPLY		60.05	1 Transactions		
252	DEPT Total:			214.42	JAIL CANTEEN ACCOUNT	3 Vendors	3 Transactions
255	DEPT				COUNTY COURT SERVICES		
	977	MIDWEST MONITORING & SURVEILLANC					
45		25-255-000-0000-6350		57.25	JAN LAB FEES		Other Services & Charges
	977	MIDWEST MONITORING & SURVEILLANC		57.25	1 Transactions		
255	DEPT Total:			57.25	COUNTY COURT SERVICES	1 Vendors	1 Transactions
285	DEPT				E-911 SYSTEM MAINTENANCE - GRANT		
	719	BLUE EARTH COUNTY					
35		25-285-000-0000-6350		1,148.74	RADIO BD DUES	9546	Other Services & Charges
	719	BLUE EARTH COUNTY		1,148.74	1 Transactions		
	5771	NU-TELECOM					
46		25-285-000-0000-6203		588.30	587-0405 E-911	81670403	Communications - Telephone Equipment
					02/01/2016 02/29/2016		
	5771	NU-TELECOM		588.30	1 Transactions		
285	DEPT Total:			1,737.04	E-911 SYSTEM MAINTENANCE - GRAN	2 Vendors	2 Transactions
614	DEPT				WETLANDS ADMINISTRATION-GRANT		
	6009	INNOVATIVE OFFICE SOLUTIONS LLC					
69		25-614-000-0000-6402		19.23	OFFICE SUPPLIES	IN1062626	Office Supplies

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
6009	INNOVATIVE OFFICE SOLUTIONS LLC		19.23	1 Transactions		
614	DEPT Total:		19.23	WETLANDS ADMINISTRATION-GRANT	1 Vendors	1 Transactions
886	DEPT			COUNTY FEEDLOT PROGRAM		
1457	PRO AUTO & TRANSMISSION REPAIR INC					
77	25-886-000-0000-6338		425.68	2006 CHEV SILVERADO MAINT	3058695	Motor Pool Expenses
1457	PRO AUTO & TRANSMISSION REPAIR INC		425.68	1 Transactions		
886	DEPT Total:		425.68	COUNTY FEEDLOT PROGRAM	1 Vendors	1 Transactions
25	Fund Total:		2,453.62	SPECIAL REVENUE FUND		8 Transactions

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	Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
852		DEPT			PROJECT HARMONY GRANT		
	2716	TIERNEY BROTHERS INC					
23		82-852-000-0000-6612		443.20	PROJECTOR	7086889	Captial - $100-$5,000 (Inventory)
	2716	TIERNEY BROTHERS INC		443.20	1 Transactions		
852		DEPT Total:		443.20	PROJECT HARMONY GRANT	1 Vendors	1 Transactions
853		DEPT			LOCAL PUBLIC HEALTH GRANT		
	718	BUERKLE/RHONDA					
37		82-853-000-0000-6121		1,512.00	LPHG GRANT TIME		Personnel Wages
38		82-853-000-0000-6335		48.60	LPHG GRANT MILEAGE		Mileage Expense
39		82-853-000-0000-6353		10.74	LPHG MEETING EXPENSE		Meeting Expense
	718	BUERKLE/RHONDA		1,571.34	3 Transactions		
	11580	CENTURYLINK					
67		82-853-000-0000-6203		4.25	LONG DISTANCE	320439462	Communications
	11580	CENTURYLINK		4.25	1 Transactions		
	9820	MINNESOTA COUNTIES COMPUTER COO					
16		82-853-000-0000-6265	AP 4	96.93	4TH QTR USER GROUP	2Y1601371	Professional Services
	9820	MINNESOTA COUNTIES COMPUTER COO		96.93	1 Transactions		
	4834	RAMSEY PRINTING INC					
21		82-853-000-0000-6265		2,650.98	CHS CLOTHING	55538	Professional Services
	4834	RAMSEY PRINTING INC		2,650.98	1 Transactions		
	2403	THE HOARDING PROJECT					
14		82-853-000-0000-6265		362.70	HOARDING PROJECT PRESENTATION		Professional Services
					01/14/2016 01/14/2016		
	2403	THE HOARDING PROJECT		362.70	1 Transactions		
853		DEPT Total:		4,686.20	LOCAL PUBLIC HEALTH GRANT	5 Vendors	7 Transactions
862		DEPT			SHIP		
	2716	TIERNEY BROTHERS INC					
22		82-862-000-0000-6612		500.00	PROJECTOR	7086889	Captial - $100-$5,000 (Inventory)
	2716	TIERNEY BROTHERS INC		500.00	1 Transactions		

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
862	DEPT Total:		500.00	SHIP	1 Vendors	1 Transactions
82	Fund Total:		5,629.40	COMMUNITY HEALTH SERVICE		9 Transactions

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Vendor No.	Name / Account/Formula	Rpt Accr	Amount	Warrant Description / Service Dates	Invoice # / Paid On Bhf #	Account/Formula Description / On Behalf of Name
975	DEPT			DNR CLEARING ACCOUNT		
	509 MINNESOTA DNR					
18	86-975-000-0000-6850		1,547.00	DNR		Collections For Other Agencies
				01/26/2016 02/01/2016		
	509 MINNESOTA DNR		1,547.00	1 Transactions		
975	DEPT Total:		1,547.00	DNR CLEARING ACCOUNT	1 Vendors	1 Transactions
976	DEPT			GAME & FISH CLEARING ACCOUNT		
	509 MINNESOTA DNR					
17	86-976-000-0000-6850		10.00	G & F		Collections For Other Agencies
				01/26/2016 02/01/2016		
	509 MINNESOTA DNR		10.00	1 Transactions		
976	DEPT Total:		10.00	GAME & FISH CLEARING ACCOUNT	1 Vendors	1 Transactions
86	Fund Total:		1,557.00	TRUST & AGENCY FUND		2 Transactions
	Final Total:		223,244.70	44 Vendors	77 Transactions	

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Recap by Fund

Fund	AMOUNT	Name
1	11,043.65	GENERAL REVENUE FUND
3	182,583.95	ROAD & BRIDGE FUND
5	19,268.25	SOLID WASTE FUND
11	708.83	HUMAN SERVICE FUND
25	2,453.62	SPECIAL REVENUE FUND
82	5,629.40	COMMUNITY HEALTH SERVICE
86	1,557.00	TRUST & AGENCY FUND
All Funds	223,244.70	Total

Approved by, ...

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MCLEOD COUNTY HIGHWAY DEPARTMENT

1400 Adams Street SE
Hutchinson, MN 55350
Project SAP 043-598-014 [SAP 043-598-014 (43J17)] - CR 58 Br. No. L2494 Replacement
Project SAP 043-599-042 - SAP 043-599-042 Old Br. L5929 Replacement
Project SAP 043-599-041 - SAP 043-599-041 Old Br L9913 Replacement
Contract Final Pay Request No. 4

Contractor: Midwest Contracting, LLC
2948 271st Avenue
Marshall, Mn 56258

Contract No. 0582
Vendor No. 0023
For Period: 11/17/2015 - 1/28/2016
Warrant # _____ Date _____

Contract Amounts

Original Contract	$400,600.00
Contract Changes	$2,580.00
Revised Contract	$403,180.00

Funds Encumbered

Original	$400,600.00
Additional	N/A
Total	$400,600.00

	Work Certified This Request	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
SAP 043-598-014 [SAP 043-598-014 (43J17)]	$540.00	$123,641.15	$0.00	$121,870.14	$1,771.01	$123,641.15
			Percent Retained: 0%			
SAP 043-599-042	$0.00	$137,031.50	$0.00	$135,661.18	$1,370.32	$137,031.50
			Percent Retained: 0%			
SAP 043-599-041	$0.00	$132,573.00	$0.00	$131,247.27	$1,325.73	$132,573.00
			Percent Retained: 0%			
Contract 0582	$540.00	$393,245.65	$0.00	$388,778.59	$4,467.06	$393,245.65
			Percent Retained: 0%			
				Amount Paid This Contract Final Pay Request	**$4,467.06**	

I hereby certify that a Final Examination has been made of the noted Contract, that the Contract has been completed, that the entire amount of Work Shown in this Final Voucher has been performed and the Total Value of the Work Performed in accordance with, and pursuant to, the terms of the Contract is as shown in this Final Voucher.

Approved By
Phillip Schultz
County/City/Project Engineer
1/28/16
Date

Approved By Midwest Contracting, LLC
Kim Boe
Contractor Kim Boe - Secretary/Treasurer
2/1/16
Date

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-598-014 [SAP 043-598-014 (43J17)], SAP 043-599-042, SAP 043-599-041
Contract Final Pay Request No. 4

Contract Payment Summary

From Date	To Date	Work Certified Per Period	Amount Retained Per Period	Amount Paid Per Period	Amount Paid To Date
06/01/2015	08/21/2015	$384,125.65	$19,206.29	$364,919.36	$364,919.36
08/22/2015	10/23/2015	$7,380.00	($15,291.23)	$22,671.23	$387,590.59
10/24/2015	11/16/2015	$1,200.00	$12.00	$1,188.00	$388,778.59
11/17/2015	01/28/2016	$540.00	($3,927.06)	$4,467.06	$393,245.65
	Totals:	**$393,245.65**	**$0.00**	**$393,245.65**	

SAP 043-598-014 [SAP 043-598-014 (43J17)] Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$121,101.15	$6,055.06	$115,046.09
2	08/22/2015	10/23/2015	$2,000.00	($4,824.05)	$6,824.05
3	10/24/2015	11/16/2015	$0.00	$0.00	$0.00
4	11/17/2015	01/28/2016	$540.00	($1,231.01)	$1,771.01
		Totals:	**$123,641.15**	**$0.00**	**$123,641.15**

SAP 043-599-042 Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$132,951.50	$6,647.58	$126,303.92
2	08/22/2015	10/23/2015	$2,880.00	($5,289.26)	$8,169.26
3	10/24/2015	11/16/2015	$1,200.00	$12.00	$1,188.00
4	11/17/2015	01/28/2016	$0.00	($1,370.32)	$1,370.32
		Totals:	**$137,031.50**	**$0.00**	**$137,031.50**

SAP 043-599-041 Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$130,073.00	$6,503.65	$123,569.35
2	08/22/2015	10/23/2015	$2,500.00	($5,177.92)	$7,677.92
3	10/24/2015	11/16/2015	$0.00	$0.00	$0.00
4	11/17/2015	01/28/2016	$0.00	($1,325.73)	$1,325.73
		Totals:	**$132,573.00**	**$0.00**	**$132,573.00**

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-598-014 [SAP 043-598-014 (43J17)], SAP 043-599-042, SAP 043-599-041
Contract Final Pay Request No. 4

McLeod County Highway Department
Certificate of Final Contract Acceptance

Low S.P. No.: SAP 043-598-014 **Final Voucher No.: 4** **Contract No.: 0582**

This is to certify that to the best of my knowledge, the items of work shown in the Statement of Work Certified herein have actually furnished in accordance with the Plans and Specifications. This Project has been completed in accordance with the Laws, Standards and Procedures of Minnesota as they apply to projects in this category, and if applicable, approved by the Federal Highway Administration.

Dated 1/28/16 Signature Phillip Schultz County/City/Project Engineer

The undersigned Contractor hereby certifies that the work described has been performed in accordance with the terms of the Contract, and agrees that the Final Value of Work Certified on this Contract is $393,245.65 and agrees to the amount of $4,467.06 as Final Payment on this Contract in accordance with this Final Voucher.

Contractor Midwest Contracting, LLC By Kim Boe
Kim Boe - Secretary/Treasurer

And _____ And _____

State of Minnesota, ~~McLeod~~ Lyon County Highway Department

On This 1st Day February, 2016, Before me appeared Kim Boe To me known to

(Individual Acknowledgment)
be the person who executed the foregoing Acceptance and Acknowledged that he/she executed the same as A free to act and deed

(Corporate Acknowledgment)
_____ And _____, to me personally known, who, being each by me duly sworn

each did say that they are respectively the _____ and _____ of the

_____ Corporation named in the foregoing instrument, and that the seal affixed to said instrument is the Corporate Seal of said Corporation, and the said instrument was signed and sealed in behalf of said Corporation by authority of its

_____ and said _____ and _____
acknowledged said instrument to be the free act and deed of said Corporation.

Notarial Seal

CHERYL A. MORETTER
Notary Public-Minnesota
My Commission Expires Jan 31, 2020

My Commission as Notary Public in Lyon County
Expires 1/31/20 Signature Cheryl A Moretter

I hereby certify that a Final Examination has been made of the noted Contract, that the Contract has been completed, that the entire amount of Work Shown in this Final Voucher has been performed and the Total Value of the Work Performed in accordance with, the terms of the Contract is as shown in this Final Voucher.
This Contract is hereby accepted in accordance with the Specification 1516. Final acceptance of the Contract will be effective upon full Execution, by the Contractor and the Department, of the "Certificate of Final Acceptance" included with the Final Voucher.

Dated _____ Signature _____ District Engineer

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-598-014 [SAP 043-598-014 (43J17)], SAP 043-599-042, SAP 043-599-041
Contract Final Pay Request No. 4

McLeod County Highway Department
Certificate of Final Acceptance
County Board Acknowledgment

Contract Number:	0582
Contractor:	0023 - Midwest Contracting, LLC
Date Certified:	1/28/2016
Payment Number:	4

Whereas; Contract No. 0582 has in all things been completed, and the County Board being fully advised in the premises, now then be it resolved; that we do hereby accept said completed project for and in behalf of the McLeod County Highway Department and authorize final payment as specified herein.

McLeod County Highway Department
State of Minnesota

I, _____, County _____ within and for said county do hereby certify that the foregoing resolution is a true and correct copy of the resolution on file in my office.

Dated this _____ day of _____, 20___

At _____, Minnesota

Signed By _____
County _____

(SEAL)

MCLEOD COUNTY HIGHWAY DEPARTMENT

1400 Adams Street SE
Hutchinson, MN 55350
Project SAP 043-598-014 [SAP 043-598-014 (43J17)] - CR 58 Br. No. L2494 Replacement
Final Pay Request No. 4

Contractor: Midwest Contracting, LLC
2948 271st Avenue
Marshall, Mn 56258

Contract No. 0582
Vendor No. 0023
For Period: 11/17/2015 - 1/28/2016
Warrant # _____ Date _____

Contract Amounts	
Original Contract	$126,760.00
Contract Changes	$0.00
Revised Contract	$126,760.00

Work Certified To Date	
Base Bid Items	$123,641.15
Backsheet	$0.00
Change Order	$0.00
Supplemental Agreement	$0.00
Work Order	$0.00
Material On Hand	$0.00
Total	$123,641.15

Funds Encumbered	
Original	$126,760.00
Additional	N/A
Total	$126,760.00

	Work Certified This Request	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
SAP 043-598-014 [SAP 043-598-014 (43J17)]	$540.00	$123,641.15	$0.00	$121,870.14	$1,771.01	$123,641.15
			Percent Retained: 0%			
				Amount Paid This Final Pay Request	$1,771.01	

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-598-014 [SAP 043-598-014 (43J17)]
Final Pay Request No. 4

SAP 043-598-014 [SAP 043-598-014 (43J17)] Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$121,101.15	$6,055.06	$115,046.09
2	08/22/2015	10/23/2015	$2,000.00	($4,824.05)	$6,824.05
3	10/24/2015	11/16/2015	$0.00	$0.00	$0.00
4	11/17/2015	01/28/2016	$540.00	($1,231.01)	$1,771.01
		Totals:	**$123,641.15**	**$0.00**	**$123,641.15**

SAP 043-598-014 [SAP 043-598-014 (43J17)] Funding Category Report

Funding Category No.	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
001	112,946.15	0.00	111,816.69	1,129.46	112,946.15
002	10,695.00	0.00	10,053.45	641.55	10,695.00
Totals:	**$123,641.15**	**$0.00**	**$121,870.14**	**$1,771.01**	**$123,641.15**

SAP 043-598-014 [SAP 043-598-014 (43J17)] Funding Source Report

Accounting No.	Funding Source	Amount Paid This Request	Revised Contract Amount	Funds Encumbered To Date	Paid To Contractor To Date
0582	Local (County)	641.55	11,060.00	11,060.00	10,695.00
0582-05	BrBnd/Oth Bnd Prgms	1,129.46	115,700.00	115,700.00	112,946.15
	Totals:	**$1,771.01**	**$126,760.00**	**$126,760.00**	**$123,641.15**

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-598-014 [SAP 043-598-014 (43J17)]
Final Pay Request No. 4

SAP 043-598-014 [SAP 043-598-014 (43J17)] Project Item Status

Line	Item	Description	Units	Unit Price	Contract Quantity	Quantity This Request	Amount This Request	Quantity To Date	Amount To Date
Base									
1	2021.501	MOBILIZATION	LUMP SUM	$6,000.00	1	0	$0.00	1	$6,000.00
2	2104.501	REMOVE PIPE CULVERTS	LIN FT	$65.00	84	0	$0.00	84	$5,460.00
3	2105.601	APPROACH GRADING	LUMP SUM	$1,000.00	1	0	$0.00	1	$1,000.00
4	2211.501	AGGREGATE BASE CLASS 5	TON	$13.00	100	0	$0.00	100	$1,300.00
5	2412.511	10X8 PRECAST CONCRETE BOX CULVERT	LIN FT	$700.00	78	0	$0.00	78	$54,600.00
6	2412.512	10X8 PRECAST CONCRETE BOX CULVERT END SECTION	EACH	$12,000.00	2	0	$0.00	2	$24,000.00
7	2451.503	GRANULAR BACKFILL (CV)	CU YD	$15.00	280	36	$540.00	146	$2,190.00
8	2451.511	COARSE FILTER AGGREGATE (CV)	CU YD	$45.00	355	0	$0.00	337	$15,165.00
9	2511.504	QUARRY RUN RIPRAP	TON	$45.00	245	0	$0.00	245.47	$11,046.15
10	2557.603	TEMPORARY FENCE DESIGN SPECIAL	LIN FT	$1.00	80	0	$0.00	80	$80.00
11	2563.601	TRAFFIC CONTROL	LUMP SUM	$800.00	1	0	$0.00	1	$800.00
12	2573.502	SILT FENCE, TYPE MACHINE SLICED	LIN FT	$1.00	320	0	$0.00	0	$0.00
13	2575.555	TURF ESTABLISHMENT	LUMP SUM	$2,000.00	1	0	$0.00	1	$2,000.00
					Totals For Base:		**$540.00**		**$123,641.15**
					Project Totals:		**$540.00**		**$123,641.15**

MCLEOD COUNTY HIGHWAY DEPARTMENT

1400 Adams Street SE
Hutchinson, MN 55350
Project SAP 043-599-042 - SAP 043-599-042 Old Br. L5929 Replacement
Final Pay Request No. 4

Contractor: Midwest Contracting, LLC
2948 271st Avenue
Marshall, Mn 56258

Contract No. 0582
Vendor No. 0023
For Period: 11/17/2015 - 1/28/2016
Warrant # _____ Date _____

Contract Amounts

Original Contract	$139,215.00
Contract Changes	$2,080.00
Revised Contract	$141,295.00

Work Certified To Date

Base Bid Items	$134,951.50
Backsheet	$0.00
Change Order	$1,200.00
Supplemental Agreement	$0.00
Work Order	$880.00
Material On Hand	$0.00
Total	$137,031.50

Funds Encumbered

Original	$139,215.00
Additional	N/A
Total	$139,215.00

	Work Certified This Request	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
SAP 043-599-042	$0.00	$137,031.50	$0.00	$135,661.18	$1,370.32	$137,031.50
			Percent Retained: 0%			
				Amount Paid This Final Pay Request	**$1,370.32**	

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-599-042
Final Pay Request No. 4

SAP 043-599-042 Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$132,951.50	$6,647.58	$126,303.92
2	08/22/2015	10/23/2015	$2,880.00	($5,289.26)	$8,169.26
3	10/24/2015	11/16/2015	$1,200.00	$12.00	$1,188.00
4	11/17/2015	01/28/2016	$0.00	($1,370.32)	$1,370.32
		Totals:	**$137,031.50**	**$0.00**	**$137,031.50**

SAP 043-599-042 Funding Category Report

Funding Category No.	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
001	123,164.50	0.00	121,932.85	1,231.65	123,164.50
002	13,867.00	0.00	13,728.33	138.67	13,867.00
Totals:	**$137,031.50**	**$0.00**	**$135,661.18**	**$1,370.32**	**$137,031.50**

SAP 043-599-042 Funding Source Report

Accounting No.	Funding Source	Amount Paid This Request	Revised Contract Amount	Funds Encumbered To Date	Paid To Contractor To Date
9942	Local (County)	100.00	10,000.00	10,000.00	10,000.00
9942-04	Town Bridge	1,270.32	131,295.00	129,215.00	127,031.50
	Totals:	**$1,370.32**	**$141,295.00**	**$139,215.00**	**$137,031.50**

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-599-042
Final Pay Request No. 4

SAP 043-599-042 Project Item Status

Line	Item	Description	Units	Unit Price	Contract Quantity	Quantity This Request	Amount This Request	Quantity To Date	Amount To Date
Base									
1	2021.501	MOBILIZATION	LUMP SUM	$6,000.00	1	0	$0.00	1	$6,000.00
14	2101.511	CLEARING & GRUBBING	LS	$2,000.00	1	0	$0.00	1	$2,000.00
2	2104.501	REMOVE PIPE CULVERTS	LIN FT	$60.00	62	0	$0.00	62	$3,720.00
3	2105.601	APPROACH GRADING	LUMP SUM	$1,000.00	1	0	$0.00	1	$1,000.00
4	2211.501	AGGREGATE BASE CLASS 5	TON	$15.00	100	0	$0.00	100	$1,500.00
5	2412.511	14X10 PRECAST CONCRETE BOX CULVERT	L F	$900.00	60	0	$0.00	60	$54,000.00
6	2412.512	14X10 PRECAST CONCRETE BOX CULV END SECT	EACH	$15,000.00	2	0	$0.00	2	$30,000.00
7	2451.503	GRANULAR BACKFILL (CV)	CU YD	$17.00	200	0	$0.00	156	$2,652.00
8	2451.511	COARSE FILTER AGGREGATE (CV)	CU YD	$48.00	350	0	$0.00	299	$14,352.00
15	2501.511	18" CS PIPE CULVERT	L F	$27.00	45	0	$0.00	45	$1,215.00
9	2511.502	RANDOM RIPRAP CLASS III	TON	$50.00	330	0	$0.00	312.65	$15,632.50
10	2557.603	TEMPORARY FENCE DESIGN SPECIAL	LIN FT	$1.00	80	0	$0.00	80	$80.00
11	2563.601	TRAFFIC CONTROL	LUMP SUM	$800.00	1	0	$0.00	1	$800.00
12	2573.502	SILT FENCE, TYPE MACHINE SLICED	LIN FT	$1.00	200	0	$0.00	0	$0.00
13	2575.555	TURF ESTABLISHMENT	LUMP SUM	$2,000.00	1	0	$0.00	1	$2,000.00
					Totals For Section Base:		**$0.00**		**$134,951.50**
Change Order 1 - Rework & Reseed									
17	2575.555	TURF ESTABLISHMENT	LS	$1,200.00	1	0	$0.00	1	$1,200.00
					Totals For Change Order 1 - Rework & Reseed:		**$0.00**		**$1,200.00**
Work Order 1 - Remove & Replace Drain Tile Outlet									
16	2511.601	Remove & Replace Drain Tile Outlet	EA	$440.00	2	0	$0.00	2	$880.00
					Totals For Work Order 1 - Remove & Replace Drain Tile Outlet:		**$0.00**		**$880.00**
					Project Totals:		**$0.00**		**$137,031.50**

SAP 043-599-042 Contract Changes

No.	Type	Date	Explanation	Estimated Amount	Amount Paid To Date
WO1	Work Order	10/5/2015	Remove & Replace Drain Tile Outlet	$880.00	$880.00
CO1	Change Order	11/13/2015	Rework and Reseed for stabilization.	$1,200.00	$1,200.00
			Contract Change Totals:	**$2,080.00**	**$2,080.00**

MCLEOD COUNTY HIGHWAY DEPARTMENT

1400 Adams Street SE
Hutchinson, MN 55350
Project SAP 043-599-041 - SAP 043-599-041 Old Br L9913 Replacement
Final Pay Request No. 4

Contractor: Midwest Contracting, LLC
2948 271st Avenue
Marshall, Mn 56258

Contract No. 0582
Vendor No. 0023
For Period: 11/17/2015 - 1/28/2016
Warrant # _____ Date _____

Contract Amounts	
Original Contract	$134,625.00
Contract Changes	$500.00
Revised Contract	$135,125.00

Work Certified To Date	
Base Bid Items	$132,073.00
Backsheet	$0.00
Change Order	$0.00
Supplemental Agreement	$0.00
Work Order	$500.00
Material On Hand	$0.00
Total	$132,573.00

Funds Encumbered	
Original	$134,625.00
Additional	N/A
Total	$134,625.00

	Work Certified This Request	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
SAP 043-599-041	$0.00	$132,573.00	$0.00	$131,247.27	$1,325.73	$132,573.00
			Percent Retained: 0%			
				Amount Paid This Final Pay Request	$1,325.73	

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-599-041
Final Pay Request No. 4

SAP 043-599-041 Payment Summary

No.	From Date	To Date	Work Certified Per Request	Amount Retained Per Request	Amount Paid Per Request
1	06/01/2015	08/21/2015	$130,073.00	$6,503.65	$123,569.35
2	08/22/2015	10/23/2015	$2,500.00	($5,177.92)	$7,677.92
3	10/24/2015	11/16/2015	$0.00	$0.00	$0.00
4	11/17/2015	01/28/2016	$0.00	($1,325.73)	$1,325.73
		Totals:	**$132,573.00**	**$0.00**	**$132,573.00**

SAP 043-599-041 Funding Category Report

Funding Category No.	Work Certified To Date	Less Amount Retained	Less Previous Payments	Amount Paid This Request	Total Amount Paid To Date
001	122,925.00	0.00	121,695.75	1,229.25	122,925.00
002	9,648.00	0.00	9,551.52	96.48	9,648.00
Totals:	**$132,573.00**	**$0.00**	**$131,247.27**	**$1,325.73**	**$132,573.00**

SAP 043-599-041 Funding Source Report

Accounting No.	Funding Source	Amount Paid This Request	Revised Contract Amount	Funds Encumbered To Date	Paid To Contractor To Date
9941	Local (County)	96.48	9,525.00	9,025.00	9,648.00
9941-04	Town Bridge	1,229.25	125,600.00	125,600.00	122,925.00
	Totals:	**$1,325.73**	**$135,125.00**	**$134,625.00**	**$132,573.00**

MCLEOD COUNTY HIGHWAY DEPARTMENT
1400 Adams Street SE
Hutchinson, MN 55350
Project No. SAP 043-599-041
Final Pay Request No. 4

SAP 043-599-041 Project Item Status

Line	Item	Description	Units	Unit Price	Contract Quantity	Quantity This Request	Amount This Request	Quantity To Date	Amount To Date
Base									
1	2021.501	MOBILIZATION	LUMP SUM	$6,000.00	1	0	$0.00	1	$6,000.00
2	2104.501	REMOVE PIPE CULVERTS	LIN FT	$60.00	66	0	$0.00	66	$3,960.00
3	2105.601	APPROACH GRADING	LUMP SUM	$1,000.00	1	0	$0.00	1	$1,000.00
4	2211.501	AGGREGATE BASE CLASS 5	TON	$17.00	105	0	$0.00	124	$2,108.00
5	2412.511	16X7 PRECAST CONCRETE BOX CULVERT	L F	$1,000.00	60	0	$0.00	60	$60,000.00
6	2412.512	16X7 PRECAST CONCRETE BOX CULV END SEC	EACH	$15,000.00	2	0	$0.00	2	$30,000.00
7	2451.503	GRANULAR BACKFILL (CV)	CU YD	$15.00	170	0	$0.00	135	$2,025.00
8	2451.511	COARSE FILTER AGGREGATE (CV)	CU YD	$50.00	325	0	$0.00	305	$15,250.00
9	2511.502	RANDOM RIPRAP CLASS III	TON	$50.00	200	0	$0.00	177	$8,850.00
10	2557.603	TEMPORARY FENCE DESIGN SPECIAL	LIN FT	$1.00	80	0	$0.00	80	$80.00
11	2563.601	TRAFFIC CONTROL	LUMP SUM	$800.00	1	0	$0.00	1	$800.00
12	2573.502	SILT FENCE, TYPE MACHINE SLICED	LIN FT	$1.00	200	0	$0.00	0	$0.00
13	2575.555	TURF ESTABLISHMENT	LUMP SUM	$2,000.00	1	0	$0.00	1	$2,000.00
					Totals For Section Base:		**$0.00**		**$132,073.00**
Work Order 1 - Repair Erosion & Additional Riprap Work									
14	2511.601	RIPRAP	LS	$500.00	1	0	$0.00	1	$500.00
					Totals For Work Order 1 - Repair Erosion & Additional Riprap Work:		**$0.00**		**$500.00**
					Project Totals:		**$0.00**		**$132,573.00**

SAP 043-599-041 Contract Changes

No.	Type	Date	Explanation	Estimated Amount	Amount Paid To Date
WO1	Work Order	10/5/2015	Repair Erosion & Additional Riprap Work	$500.00	$500.00
			Contract Change Totals:	**$500.00**	**$500.00**

Date: 2/9/2016
Time: 03:20 pm
Fringe Benefits Included
From: 01-0000-2015
Through: 12-9999-2015

MCLEOD COUNTY HIGHWAY COSTING SYSTEM

Cost Account Ledger - Sorted Detail

Line Detail

Year	Per	Batch	Line	Employee/Equipment/Material		Labor Cost (Hrs)	Equipment Cost (Hr/Mi)	Material Cost (Qty)	Other Debit	Credits	Total Cost
61-0201 - MAINTAIN BITUMINOUS ROADS											
		Customer		**0003**	**COLLINS TOWNSHIP**						
2015	8	18	498	0460	MICHAELIS, BRYAN	73.32 (2.00)					73.32
2015	9	16	481	0460	MICHAELIS, BRYAN	109.98 (3.00)					109.98
2015	9	31	358	0460	MICHAELIS, BRYAN	91.66 (2.50)					91.66
2015	9	16	101	1276	DERRY, KIM	89.67 (3.00)					89.67
2015	9	31	500	1414	ZAJICEK, JASON	66.66 (2.50)					66.66
2015	9	16	136	1542	DUMMER, KEENAN	106.66 (4.00)					106.66
2015	9	16	371	1700	KUBE, THOMAS	80.00 (3.00)					80.00
2015	8	18	261	1749	IDE, JOEL	51.65 (2.00)					51.65
2015	9	16	256	1749	IDE, JOEL	77.47 (3.00)					77.47
2015	9	31	178	1749	IDE, JOEL	64.56 (2.50)					64.56
2015	8	18	57	1754	BASS, ETHAN	22.07 (2.00)					22.07
2015	8	18	392	1756	KURTIS, KUNKEL	22.07 (2.00)					22.07
		Total Employees				855.77 (31.50)					855.77
2015	9	16	242	0020	2004 CHEV 3/4 TON 4WD PICKUP #		27.00 (3.00)				27.00
2015	9	31	198	0020	2004 CHEV 3/4 TON 4WD PICKUP #		22.50 (2.50)				22.50
2015	9	16	73	0120	2006 FORD 1 TON CB PICKUP #271		9.00 (1.00)				9.00
2015	8	18	48	0210	2010 GMC RED PICKUP #6421		18.00 (2.00)				18.00
2015	9	16	71	0580	2010 CAT ROLLER CB24 #6631		50.00 (2.00)				50.00
2015	9	31	514	0580	2010 CAT ROLLER CB24 #6631		50.00 (2.00)				50.00
2015	8	18	479	0910	2000 FRTLNER W/ PATCHING TRLR		70.00 (2.00)				70.00
2015	9	16	460	0910	2000 FRTLNER W/ PATCHING TRLR		105.00 (3.00)				105.00
2015	9	31	374	0910	2000 FRTLNER W/ PATCHING TRLR		87.50 (2.50)				87.50
2015	9	16	72	1408	2015 TOWMASTER TM-14DT TRAILE		11.00 (1.00)				11.00
		Total Equipment					450.00 (21.00)				450.00
2015	8	14	4	4103	WINTER COLD MIX FOR PATCHING			120.23 (.75)			120.23
2015	9	12	6	4103	WINTER COLD MIX FOR PATCHING			440.85 (2.75)			440.85
2015	9	27	2	4103	WINTER COLD MIX FOR PATCHING			240.47 (1.50)			240.47
		Total Materials						801.55 (5.00)			801.55
		Total Customer		**0003**		855.77 (31.50)	450.00 (21.00)	801.55 (5.00)			2,107.32
Total		61-0201 - MAINTAIN BITUMINOUS ROADS				855.77 (31.50)	450.00 (21.00)	801.55 (5.00)			2,107.32
61-5006 - MISCELLANEOUS ITEMS											
		Customer		**0003**	**COLLINS TOWNSHIP**						
2015	11	6	4	0145	BANDAS, RAYMOND JR	300.02 (8.00)					300.02
2015	11	6	10	0145	BANDAS, RAYMOND JR	37.39 (1.00)					37.39

MCLEOD COUNTY HIGHWAY COSTING SYSTEM

Cost Account Ledger - Sorted Detail

Fringe Benefits Included
From: 01-0000-2015
Through: 12-9999-2015

Line Detail

Year	Per	Batch	Line	Employee/Equipment/Material		Labor Cost (Hrs)	Equipment Cost (Hr/Mi)	Material Cost (Qty)	Other Debit	Credits	Total Cost
61-5006 - MISCELLANEOUS ITEMS											
		Customer		**0003**	**COLLINS TOWNSHIP**						
2015	11	6	11	0145	BANDAS, RAYMOND JR	300.02 (8.00)					300.02
2015	11	6	302	0273	KARG, DOUGLAS	84.86 (2.50)					84.86
2015	11	6	305	0273	KARG, DOUGLAS	271.51 (8.00)					271.51
2015	11	6	306	0273	KARG, DOUGLAS	16.91 (.50)					16.91
2015	11	6	498	0460	MICHAELIS, BRYAN	293.28 (8.00)					293.28
2015	11	6	499	0460	MICHAELIS, BRYAN	183.30 (5.00)					183.30
2015	11	6	566	0489	SCHOMMER, PATRICK KEVIN	271.51 (8.00)					271.51
2015	11	6	567	0489	SCHOMMER, PATRICK KEVIN	271.51 (8.00)					271.51
2015	11	6	385	1353	MESSNER, PHILIP	58.42 (2.00)					58.42
2015	11	6	387	1353	MESSNER, PHILIP	146.04 (5.00)					146.04
2015	11	6	340	1700	KUBE, THOMAS	13.29 (.50)					13.29
2015	11	6	358	1700	KUBE, THOMAS	159.99 (6.00)					159.99
2015	11	6	359	1700	KUBE, THOMAS	213.32 (8.00)					213.32
2015	11	6	248	1749	IDE, JOEL	206.58 (8.00)					206.58
2015	11	6	250	1749	IDE, JOEL	129.11 (5.00)					129.11
		Total Employees				2,957.06 (91.50)					2,957.06
2015	11	6	572	0430	2008 CAT 430E BACKHOE #3621		330.00 (5.50)				330.00
2015	11	6	611	0430	2008 CAT 430E BACKHOE #3621		300.00 (5.00)				300.00
2015	11	6	606	0810	2000 QUIPNET TAG TRAILER 32' #5		11.00 (1.00)				11.00
2015	11	6	608	0810	2000 QUIPNET TAG TRAILER 32' #5		13.75 (1.25)				13.75
2015	11	6	310	0930	1993 CAT LOADER #5042		120.00 (2.00)				120.00
2015	11	6	407	0930	1993 CAT LOADER #5042		120.00 (2.00)				120.00
2015	11	6	607	1010	2006 STERLING LT9500 TANDEM #2		70.00 (1.00)				70.00
2015	11	6	609	1010	2006 STERLING LT9500 TANDEM #2		70.00 (1.00)				70.00
2015	11	6	51	1201	2013 MACK TANDEM TRUCK #6790		350.00 (5.00)				350.00
2015	11	6	55	1201	2013 MACK TANDEM TRUCK #6790		420.00 (6.00)				420.00
2015	11	6	367	1301	2013 BOBCAT SKID LOADER #7409		150.00 (5.00)				150.00
2015	11	6	369	1301	2013 BOBCAT SKID LOADER #7409		180.00 (6.00)				180.00
2015	11	6	610	1301	2013 BOBCAT SKID LOADER #7409		60.00 (2.00)				60.00
2015	11	6	513	2030	2005 STERLING LT9500 TANDEM #9		350.00 (5.00)				350.00
2015	11	6	514	2030	2005 STERLING LT9500 TANDEM #9		350.00 (5.00)				350.00
2015	11	6	333	3050	2007 CATERPILLAR 12H GRADER #3		162.50 (2.50)				162.50
2015	11	6	336	3050	2007 CATERPILLAR 12H GRADER #3		65.00 (1.00)				65.00
2015	11	6	338	3050	2007 CATERPILLAR 12H GRADER #3		32.50 (.50)				32.50
2015	11	6	506	3050	2007 CATERPILLAR 12H GRADER #3		65.00 (1.00)				65.00

Date: 2/9/2016
Time: 03:20 pm
Fringe Benefits Included
From: 01-0000-2015
Through: 12-9999-2015

MCLEOD COUNTY HIGHWAY COSTING SYSTEM

Cost Account Ledger - Sorted Detail

Line Detail

Year	Per	Batch	Line	Employee/Equipment/Material	Labor Cost (Hrs)	Equipment Cost (Hr/Mi)	Material Cost (Qty)	Other Debit	Credits	Total Cost
61-5006 - MISCELLANEOUS ITEMS										
		Customer		**0003 COLLINS TOWNSHIP**						
2015	11	6	332	3051 2010 WALK N ROLL PACKER #6422		15.00 (2.50)				15.00
2015	11	6	409	4060 2004 STERLING TANDEM TRUCK #5		280.00 (4.00)				280.00
2015	11	6	337	5020 1999 STERLING TANDEM PLOW TRK		280.00 (4.00)				280.00
2015	11	6	276	5030 2000 STERLING TANDEM #5059		350.00 (5.00)				350.00
2015	11	6	286	5030 2000 STERLING TANDEM #5059		560.00 (8.00)				560.00
		Total Equipment				4,704.75 (81.25)				4,704.75
2015	11	2	2	4802 GEOTECH FABRIC			338.00 (260.00)			338.00
		Total Materials					338.00 (260.00)			338.00
		Total Customer		**0003**	2,957.06 (91.50)	4,704.75 (81.25)	338.00 (260.00)			7,999.81
Total		61-5006 - MISCELLANEOUS ITEMS			2,957.06 (91.50)	4,704.75 (81.25)	338.00 (260.00)			7,999.81
61-5009 - GRAVEL										
		Customer		**0003 COLLINS TOWNSHIP**						
2015	8	6	18	1233 BARTA, NATHAN	114.99 (3.00)					114.99
		Total Employees			114.99 (3.00)					114.99
		Total Customer		**0003**	114.99 (3.00)					114.99
Total		61-5009 - GRAVEL			114.99 (3.00)					114.99
Total		AUTHORIZED WORK FOR OTHERS			3,927.82 (126.00)	5,154.75 (102.25)	1,139.55 (265.00)			10,222.12
Total					3,927.82	5,154.75	1,139.55	.00	.00	10,222.12

Record Count 98

Stonebrooke
Engineering Responsible Solutions

a 12279 Nicollet Ave S. Burnsville, MN 55337
o 952.402.9202 f 952.403.6803
w stonebrookeengineering.com

February 9, 2016

Mr. John T. Brunkhorst, PE
McLeod County Engineer
1400 Adams Street SE
Hutchinson, MN 55350

RE: Bridge 43001 Replacement Proposal

Dear John:

Thank you for the opportunity to provide a proposal for engineering services to replace Bridge 43001 in McLeod County.

We have prepared our proposed scope and fee for design services in the format of "EXHIBIT A" which is attached to this letter. If you find our proposal acceptable, the "EXHIBIT A" can be attached to Stonebrooke's or the County's standard contract as authorization for us to proceed with the project.

In addition, we have prepared a proposed scope and fee for possible construction services in the format of "EXHIBIT B" which is attached to this letter after "EXHIBIT A". If you determine that you would like us to conduct construction services and find our proposal acceptable, the "EXHIBIT B" can be attached to Stonebrooke's Work Order or the County's standard agreement or amendment, as authorization for us to proceed with that portion of the project.

Please do not hesitate to contact us should you have any questions on our proposed services. Thank you again for this opportunity, and we look forward to working with McLeod County on this bridge replacement project.

Sincerely,

Ron Benson

Ron Benson, PE
Bridge Engineering Manager
(952) 540-4851

EXHIBIT A

1. Project Description/Understanding

McLeod County, through its Highway Department ("County") plans to replace Bridge No. 43001 which is located on Glencoe Township Road 207 and crosses over Buffalo Creek. This existing bridge consists of three (3) steel beam spans and is approximately 183 feet long. The bridge carries two lanes of traffic, one in each direction, with a 28-foot roadway width. The current Structure Inventory report indicates a bridge Sufficiency Rating of 76.6 and a Structurally Deficient status.

Stonebrooke Engineering, Inc. ("Engineer") understands McLeod County desires Engineer to furnish engineering services necessary to design a replacement bridge for Bridge No. 43001 ("the Project"). Construction is expected to occur in early 2017, and it is intended to have design, plans, and construction documents approved prior to the end of 2016. The proposed bridge is not expected to have any aesthetic treatments.

2. Basic Services

Based on the Engineer's understanding of the Project, the following Basic Services for design are proposed for this bridge replacement project.

1. Project Administration

1.1 The Engineer shall conduct Project Management duties, contract administration, maintaining the project work schedule, documenting communications, resolving and documenting plan review comments and providing responses for submittals, and updating the project scope and budget as necessary.

2. Survey

2.1. The Engineer shall perform a survey of the site to locate exposed utilities, right-of-way, wetland boundaries, existing structure, topographic data around the bridge, and document existing roadway alignment.

2.2. The Engineer shall perform a survey of the site to obtain for the hydraulic study: stream bottom elevations, stream profile, water surface elevation, and cross sections upstream, downstream and at the bridge opening.

2.3. The Engineer shall contact Gopher One to obtain locations of underground utilities, and coordinate with utility owners. Utility information will be added to the Survey sheets in the Project plans.

3. Geotechnical

3.1. The Engineer shall coordinate with a Geotechnical Consultant and the County will be invoiced directly.

3.2. With assistance from the Engineer, the County shall contract services directly from a Geotechnical Consultant to review the proposed site, obtain soil borings and provide foundation recommendations for structure support.

4. Pre-demolition Site Inspection and Report for Asbestos and Regulated Waste

4.1. The Engineer shall coordinate with a certified inspection constultant and the County will be invoiced directly. The Engineer shall include findings as appropriate in the Project Special Provisions.

4.2. With assistance from the Engineer, the County shall contract services directly from a Consultant licensed and certified by the Minnesota Department of Health to perform asbestos and regulated waste assessments for the bridge.

5. Hydraulics

5.1. The Engineer shall conduct a hydraulic evaluation of the structure including determining peak flow rates, water surface elevations and scour depth.

5.2. The Engineer shall determine the peak flow rates for modeling the bridge. Peak flow rates will be taken from Flood Insurance Studies and compared to other available hydrology.

5.3. The Engineer will prepare a HEC-RAS model of the bridge to determine water surface elevations and velocities for the design flood and 500-year (or overtopping) peak flows.

5.4. The Engineer shall prepare a Waterway Study Report and Risk Assessment for submittal to the County and Mn/DOT along with preliminary bridge plans.

5.5. The Engineer shall perform calculations to predict scour depth for the bridge following Mn/DOT standards. Predicted scour depth and code will be noted on the Bridge Survey Sheet.

6. Preliminary Structure Selection

6.1. The Engineer shall prepare a brief report, for County review and comment, describing three possible structure types for the site. Justification, hydraulic impacts and preliminary cost estimates shall be included in the report for discussion.

6.2. The County shall review the report and discuss with the Engineer a recommendation for the preferred proposed structure type.

7. Project Reports & Funding

7.1. If requested, the Engineer shall prepare variance documentation for the Design Study for those design elements that do not meet State Aid Operations Rules Chapter 8820. The Engineer shall use MnDOT checklists, the Design Exception Template and procedures to develop the justification. This work task, including participation in Variance Committee meetings shall be performed as a pre-authorized supplemental service.

7.2. The County will complete the MnDOT Application for Bridge Funds – State of Minnesota – Department of Transportation, State Aid for Local Transportation, and obtain Project and Bridge Numbers for the replacement project from MnDOT. If requested, the Engineer will assist with these tasks.

8. Preliminary Structure Plans

8.1. The Engineer shall determine the structure span lengths and roadway/bridge deck clear width based on functional requirements outlined in Mn/DOT's State Aid Standards, along with the completed hydraulic study.

8.2. The Engineer shall prepare preliminary structure plans; one set will be submitted to the County, one to the District and three to Mn/DOT State Aid Bridge. The structure type shall be based on the mutually selected option. The preliminary plans shall include the items listed in the State Aid Preliminary Bridge Plan Review Check List and other appropriate documents such as geotechnical report, Hydraulic Study Report and Risk Assessment Report.

9. Final Structure Plans

9.1. The Engineer shall prepare an engineering design for the selected structure type. Structure design shall be based on current AASHTO LRFD Specifications and Mn/DOT LRFD Bridge Design Manual.

9.2. The Engineer shall calculate Inventory and Operating Load Ratings for the superstructure and shall be shown on the General Plan and Elevation sheet. The Load Rating sheet shall be provided to the County, along with the electronic rating file.

9.3. The Engineer shall prepare final bridge plans; and submit one set to the County and two sets to Mn/DOT State Aid Bridge. Plans shall include quantities for the Project by item number in accordance with the 2016 Mn/DOT Standard Specification for Construction and Trns*port Item List.

10. Final Road Approach Plans

10.1. The Engineer shall prepare an engineering design of the roadway approaches to the structure, to the limits necessary for the bridge replacement and immediate approaches to meet required geometric design standards. The expected length of approach work is expected to be less than

1000 feet. The vertical alignment may be adjusted to accommodate the new structure. The existing horizontal alignment is expected to be utilized. The County shall assist the Township with obtaining new right-of-way if required.

10.2. The Engineer shall prepare traffic control plans for road closure during construction. Plans shall include provisions for appropriate traffic control devices for road closure, and a signed detour route if needed.

10.3. The Engineer shall prepare and submit roadway approach plans including plan and profile, existing and proposed cross sections, grading quantities, erosion control, turf establishment and traffic control to the County. Plans shall include quantities for the Project by item number in accordance with the 2016 Mn/DOT Standard Specification for Construction and Trns*port Item List.

11. Final Structure Plans and Special Provisions (Signed)

11.1. The Engineer shall incorporate review comments from final structure plan submittal into a revised final plan set and submit one set of certified (by signature) structure plans to the County.

11.2. The Engineer shall prepare special provisions for the structure (Division SB) and submit one original certified (by signature) copy to the County.

11.3. The Engineer shall prepare and submit an engineer's estimate of project cost to the County.

11.4. The Engineer shall complete State Aid Plans Checklist and Lab Services Request for submittal to MnDOT.

12. Final Road Approach Plan (Signed)

12.1. The Engineer shall incorporate review comments from final roadway plan submittal into a revised final plan set and submit one set of certified (by signature) approach plans to the County.

12.2. The Engineer shall prepare and submit an engineer's estimate of project cost to the County.

13. Permitting

13.1. The Engineer shall review existing site conditions and survey, and prepare exhibits and correspondence with agencies for jurisdictional determinations.

13.2. The Engineer shall review wetland boundary maps and incorporate data into exhibits if requested by permitting agencies. Wetland delineation, if needed, shall be a supplemental service.

13.3. The Engineer shall complete DNR, COE, watershed district permits as applicable for the Project. Permit fees shall be paid by the County.

13.4. The Engineer will prepare a SWPPP for inclusion in the plans. It is assumed the contractor shall prepare NPDES permit application and supporting documents in accordance with agency requirements if required based on project area.

14. Bidding Services

14.1. The County shall be responsible for advertising the Project for construction bidding. The County shall also be responsible for preparation, printing, and distribution of the Project manual, addenda processing, bid opening, and the review/analysis of bids.

14.2. The Engineer shall be available to answer technical questions during the bid process.

3. Supplemental Services

If authorized by the County, the Engineer may provide Supplemental Services. If requested, an estimated fee for these services will be provided by the Engineer prior to authorization.

4. Compensation

1. **Basic Services, Design and Plans** - Estimated Fee by Task.

See Exhibit A – Design Services Costs Breakdown attached, for additional cost detail.

Compensation for Engineer's Basic Services will be made on an hourly basis estimated as shown below. Actual costs shall not exceed the total shown without prior authorization. The following is an estimated breakdown of the fees by Task for the Basic Services.

Task	Name	Estimated Fee
1.	Project Administration	$350
2.	Survey [1]	$3,267
3.	Geotechnical [2]	$211
4.	Pre-demolition Site Inspection and Report [2]	$211
5.	Hydraulics	$2,205
6.	Preliminary Structure Selection	$350
7.	Project Reports and Funding	$154
8.	Preliminary Structure Plans	$4,388
9.	Final Structure Plans	$13,580
10.	Final Road Approach Plans	$6,805
11.	Final Structure Plans and Special Provisions (Signed)	$1,870
12.	Final Road Approach Plans (Signed)	$668
13.	Permitting [3]	$931
14.	Bid Services	$0
	Total Estimated Cost (Not to Exceed)	$34,990.00

Estimated Reimbursable Expenses (deliveries, printing, permit fees, etc.)	$160

[1] Mileage expense is incorporated into the Task 2 hourly survey crew rate.

[2] Some services identified in the task description will be performed by an outside Consultant under direct contract with the County and invoice will go to the County. Engineer will coordinate with County/Consultant. Estimated fee shown is for Engineer's services.

[3] Engineer will coordinate with agencies, prepare permits, and work with the County in endeavoring to obtain permit approvals. The Engineer cannot control the direction or actions of these various agencies, which may increase or decrease project efforts. See "Basic Services" description of Basic and Supplemental Services.

5. Preliminary Project Schedule

The following represents our proposed estimated project Task completion dates.

Task Name		Estimated Completion
2.0	Survey [1]	3 weeks after receipt of authorization to proceed
3.0	Geotechnical [2]	6 weeks after receipt of authorization to proceed
4.0	Pre-demolition Site Inspection and Report [2]	6 weeks after receipt of authorization to proceed
5.0	Hydraulics	3 weeks after completion of survey
6.0	Preliminary Structure Selection	4 weeks after completion of survey
7.0	Project Reports and Funding	As needed
8.0	Preliminary Structure Plans	7 weeks after completion of survey
9.0	Final Structure Plans	7 weeks after receipt of reviewed preliminary plans
10.0	Final Road Approach Plans	8 weeks after receipt of reviewed preliminary plans
11.0	Final Structure Plans/	
	Special Provisions (Signed)	3 weeks after receipt of reviewed final plans
12.0	Final Road Approach Plans (signed)	3 weeks after receipt of reviewed final plans
13.0	Permitting	In conjunction with plan preparation

[1] Stonebrooke has a survey crew available to complete the field survey as soon as possible upon authorization to proceed, but the survey will be scheduled in consideration of weather conditions as extreme cold with temperatures that are well below average make field survey work difficult and less efficient.

[2] Some services identified in the task description will be performed by an outside Consultant, therefore the completion schedule shown may vary.

EXHIBIT A - DESIGN SERVICES COSTS BREAKDOWN

Stonebrooke Engineering Fees for Replacement of Bridge No. 43001

Estimated Fees (p. 1 of 2)

Project Team

Category	Hourly Rate	Function
Senior Bridge Engineer	$175	PM, Responsible Engineer
Bridge Engineer	$115	Structural Design and Checking
Project Engineer	$105	Hydraulics
Design Engineer	$77	Assist w/Design, Plans, Checking
Senior Engineering Technician	$78	Plan Preparation
Engineering Technician	$60	Plan Preparation

Work Program Tasks and Fee Summary

Work Task	**Est. Fee**
Task 1 - Project Administration	$350
Task 2 - Survey	$3,267
Task 3/4 - Geotechnical/Regulated Waste *	$422
Task 5 - Hydraulics	$2,205
Task 6 - Preliminary Structure Selection	$350
Task 7 - Project Reports and Funding	$154
Task 8 - Preliminary Structure Plans	$4,388
Task 9 - Final Structure Plans	$13,580
Task 10 - Final Road Approach Plans	$6,805
Task 11 - Final Structure Plans and Special Provisions (signed)	$1,870
Task 12 - Final Road Approach Plan (signed)	$668
Task 13 - Permitting	$931
Estimated Fee	**$34,990**

Expenses - Estimated Cost **	**$160**

Total Consultant Fee (including expenses) ***	**$35,150**

* Geotechnical and Regulated Waste work shown is for consultant's coordination fee. County will be invoiced directly by firm performing the services.

** Reimbursible type expenses including: Permit fees, printing, deliveries

*** Total Consultant Fee is Not to Exceed

For McLeod County Highway Department

Replacement of Bridge No. 43001

Person Hours: Estimated Breakdown (p. 2 of 2)

Task	Description	Senior Bridge Engineer	Bridge Engineer	Project Engineer	Design Engineer	Senior Engineering Technician	Engineering Technician	Total
1	Project Administration							
	Total Estimated Labor Hours	2	0	0	0	0	0	2
	Total Estimated Fee for Task							$350
2	Survey							
	Total Estimated Labor Hours	0	0	17	0	19	0	36
	Total Estimated Fee for Task							$3,267
3 4	Geotechnical/Regulated Waste							
	Total Estimated Labor Hours	0	3	0	1	0	0	4
	Total Estimated Fee for Task							$422
5	Hydraulics							
	Total Estimated Labor Hours	3	0	16	0	0	0	19
	Total Estimated Fee for Task							$2,205
6	Preliminary Structure Selection							
	Total Estimated Labor Hours	2	0	0	0	0	0	2
	Total Estimated Fee for Task							$350
7	Project Reports and Funding							
	Total Estimated Labor Hours	0	0	0	2	0	0	2
	Total Estimated Fee for Task							$154
8	Preliminary Structure Plans							
	Total Estimated Labor Hours	5	9	1	9	10	15	49
	Total Estimated Fee for Task							$4,388
9	Final Structure Plans							
	Total Estimated Labor Hours	6	20	0	30	40	80	176
	Total Estimated Fee for Task							$13,580
10	Final Road Approach Plans							
	Total Estimated Labor Hours	6	0	0	17	17	52	92
	Total Estimated Fee for Task							$6,805
11	Final Structure Plans and Special Provision (signed)							
	Total Estimated Labor Hours	4	6	0	0	0	8	18
	Total Estimated Fee for Task							$1,870
12	Final Road Approach Plan (signed)							
	Total Estimated Labor Hours	1	1	0	0	1	5	8
	Total Estimated Fee for Task							$668
13	Permitting							
	Total Estimated Labor Hours	1	0	5	3	0	0	9
	Total Estimated Fee for Task							$931

EXHIBIT B

1. Project Description/Understanding

McLeod County, through its Highway Department ("County") plans to replace Bridge No. 43001 which is located on Glencoe Township Road 207 and crosses over Buffalo Creek. The new bridge design and plans will be completed under the design Agreement scope.

Stonebrooke Engineering, Inc. ("Engineer") understands McLeod County desires Engineer to furnish engineering services during construction of the bridge to replace Bridge No. 43001 ("the Project"). Construction is expected to occur in early 2017.

2. Basic Services

Based on the Engineer's understanding of the Project, the following Basic Services during construction are proposed for this bridge replacement project.

1. Project Management

1.1 The Engineer shall conduct Project Management duties including scheduling of personnel, documenting communications, and updating the project scope and budget as necessary.

2. Construction Services

2.1. The Engineer shall provide construction observers to observe construction activities and compliance with project specifications and MnDOT State Aid requirements.

2.2. The Engineer's on-site Construction Representative shall perform the following:

- 2.2.1. Review plans and specifications before pre-construction conference
- 2.2.2. Assist with and attend pre-construction conference
- 2.2.3. Observe bridge and roadway construction activities
- 2.2.4. Perform onsite testing and inspection of materials, and verification of placement
- 2.2.5. Keep construction diary reporting daily activities
- 2.2.6. Review contractor claims for work quantities completed
- 2.2.7. Collect documentation for work quantities completed
- 2.2.8. Submit Work Performance forms for partial payments
- 2.2.9. Coordinate field activities of survey crews
- 2.2.10. Prepare weekly construction reports
- 2.2.11. Monitor contractor's wage rates
- 2.2.12. Document changes from plans and specifications
- 2.2.13. Prepare punch list and conduct final inspection
- 2.2.14. Project closeout documentation

3. Construction Staking and Surveying

3.1. The Engineer shall provide staking for the bridge and road within tolerances as described in the MnDOT Surveys Manual.

3.2. The Engineer shall perform the following:
- 3.2.1. Alignment and grade stakes for the bridge and road construction
- 3.2.2. Alignment and elevation checks during construction
- 3.2.3. Beam Stool heights if applicable

3. Supplemental Services

If authorized by the County, the Engineer may provide Supplemental Services. If requested, an estimated fee for these services will be provided by the Engineer prior to authorization.

4. Compensation

1. **Basic Services, Construction Observation** - Estimated Fee by Task.
   See Exhibit B – Construction Services Costs Breakdown attached, for additional cost detail.

Compensation for Engineer's Basic Services, Construction Observation will be made on an hourly basis estimated as shown below. Actual costs shall not exceed the total shown without prior authorization. The following is an estimated breakdown of the fees by Task for the Basic Services.

Upon completion of the design plans when construction details are known, Engineer will coordinate with the County when filling out MnDOT's Lab Services Request form for offsite testing (such as aggregate testing and concrete cylinder breaks) and plant inspection. This offsite testing and inspection can be completed by MnDOT, a testing company, or the Engineer as a Supplemental Service. [5]

Task	Name	Estimated Fee
1.	Project Management	$525
2.	Construction Services[4]	$49,895
3.	Construction Staking and Surveying	$4,955
	Total Estimated Cost (Not to Exceed)	$55,375.00

Estimated Reimbursable Expenses (mileage, deliveries, printing, etc.) [4]	$4600

[4] Fee assumes 60 Working Days, fee is estimated prior to any design work having been completed. Estimated fee is based on an hourly rate of $85/hour which shall be used for any additional time required for added Working Days, participation in offsite testing or inspection, or additional hours for any Supplemental Services.

[5] MnDOT performs shop inspection of precast concrete fabrication.

EXHIBIT B - CONSTRUCTION SERVICES COSTS BREAKDOWN

Stonebrooke Engineering Fees for Replacement of Bridge No. 43001

Estimated Fees (p. 1 of 2)

Project Team

Category	Hourly Rate	Function
Senior Bridge Engineer	$175	PM, Responsible Engineer
Bridge Engineer	$115	NA
Project Engineer	$105	NA
Certified Inspector	$85	Construction Observation/onsite tests
Senior Engineering Technician	$95	Staking and Surveying
Engineering Technician	$60	NA

Work Program Tasks and Fee Summary

Work Task	**Est. Fee**
Task 1 - Project Management	$525
Task 2 - Construction Services	$49,895
Task 3 - Construction Staking and Surveying	$4,955
Estimated Fee	**$55,375**

Expenses - Estimated Cost **	**$4,600**

Total Consultant Fee (including expenses) ***	**$59,975**

* Not used

** Reimbursible type expenses including: Mileage, deliveries, printing

*** Total Consultant Fee is Not to Exceed

For McLeod County Highway Department

Replacement of Bridge No. 43001

Person Hours: Estimated Breakdown (p. 2 of 2)

Task	/	Description	Senior Bridge Engineer	Bridge Engineer	Project Engineer	Certified Inspector	Senior Engineering Technician	Engineering Technician	Total
1		Project Management							
		Total Estimated Labor Hours	3	0	0	0	0	0	3
		Total Estimated Fee for Task							$525
2		Construction Services							
		Total Estimated Labor Hours	0	0	0	587	0	0	587
		Total Estimated Fee for Task							$49,895
3		Construction Staking and Surveying							
		Total Estimated Labor Hours	0	0	0	27	28	0	55
		Total Estimated Fee for Task							$4,955

ERICKSON
ENGINEERING

Erickson Engineering Co., LLC
9330 James Ave S
Bloomington, MN 55431

ph 952-929-6791, 800-545-8020
fx 952-929-2909

info@erickson-eng.com
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Tom Wilson, P.E., Vice President
952-929-6791 ext. 223
twilson@erickson-eng.com

ENGINEERING SERVICES AGREEMENT between

MCLEOD COUNTY

and

ERICKSON ENGINEERING CO., LLC

for Replacement of Existing Bridge 43001

on Hamlet Avenue over Buffalo Creek

Sec 23, Twp 115 N, Rge 28 W

Erickson Engineering Agreement 16014, February 9, 2016

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A PROJECT DESCRIPTION

McLeod County is planning to replace Bridge 43001 on Hamlet Avenue. The inplace structure was built in 1963, and consists of a 3-span steel beam structure, approximately 183 ft long with a 28 ft clear width. The bridge is listed as structurally deficient and has a sufficiency rating of 76.6.

The proposed replacement structure is anticipated to be a 3-span prestressed concrete beam bridge. Viable replacement options will be investigated and presented to McLeod County during the hydraulics / preliminary design phase.

B SERVICES

In this document, "Client" refers to McLeod County and "Consultant" refers to Erickson Engineering Co., LLC.

The Consultant agrees to provide the following services to the Client in connection with the aforementioned project, according to the terms of this agreement.

1.0 SURVEY

1.1 The Consultant shall perform field survey work for the existing bridge and roadway approaches, and obtain information needed to complete the bridge survey sheets according to the MnDOT State Aid Manual.

1.2 The Consultant shall prepare the bridge survey sheet.

2.0 HYDRAULICS

2.1 The Consultant shall prepare a hydraulic flood analysis for the stream crossing. The analysis will contain data required by State and Federal agencies, including a risk assessment and a scour analysis. The Consultant will use HEC-RAS, WSPRO, or HY-8 software.

3.0 PRELIMINARY DESIGN

3.1 The Consultant shall prepare and submit to the Client preliminary design information for recommended replacement options. The preliminary design information will include general features, dimensions, and cost estimates.

4.0 MEETINGS

4.1 The Consultant will meet with the Client as necessary during the design phase of the project. A minimum of two meetings are anticipated:

- Kickoff Meeting
- Review comments after 30% completion submittal

5.0 PERMITS AND UTILITY COORDINATION

5.1 The Consultant shall apply for a MN DNR permit. *The Client shall pay the permit fees.*

5.2 The Consultant shall apply for a U.S. Army Corps of Engineers permit.

5.3 The Consultant shall perform utility investigation and coordination necessary for preliminary and final design.

6.0 WETLAND DELINEATION

6.1 According to the U.S. Fish and Wildlife Service website, there are wetlands immediately adjacent to this bridge site. If necessary, a wetland delineation will be performed to assist with the permit application process.

7.0 ASBESTOS AND REGULATED WASTE ASSESSMENT

7.1 The Consultant shall retain Carlson McCain to prepare an Asbestos and Regulated Waste Assessment of the existing bridge. The cost of this assessment is included in Table 1 of Section C - Compensation.

8.0 SOILS

8.1 The Consultant shall retain Chosen Valley Testing to obtain test borings and determine the foundation conditions at the proposed structure site. CVT will prepare a report which will include recommendations for the foundation design of the proposed bridge. The cost of this testing and report is included in Table 1 of Section C - Compensation.

9.0 BRIDGE DESIGN / PLANS

9.1 The Consultant shall prepare one preliminary bridge plan for the proposed structure. The preliminary plan will include general features, dimensions, and basic design requirements. The Consultant shall prepare the preliminary plan according to MnDOT State Aid and FHWA Standards.

9.2 The Consultant shall prepare a complete engineering design for the proposed structure. The Consultant shall design the structure to conform to current AASHTO Design Specifications, MnDOT standards, and FHWA standards.

9.3 The Consultant shall prepare one final detail bridge plan in digital format and plotted on reproducible material in ink. The Consultant shall prepare the plan according to MnDOT Bridge Design Specifications and MnDOT Standard Specifications for Construction.

9.4 The Consultant shall prepare the Division SB special provisions, construction cost estimate, plan review checklist, and load rating for the proposed structure.

9.5 The Consultant shall submit the plans and supporting documentation to the Client and MnDOT for review and approval.

9.6 If required, the Consultant shall provide the Client with beam stool height information needed for construction.

10.0 ROADWAY DESIGN / PLANS

10.1 The Consultant shall prepare preliminary and final roadway plans in digital format and plotted on reproducible material in ink. These plans will show the geometric design of the roadway, including plan and profile, specific design features in terms of horizontal and vertical alignment, typical section, width, erosion control, easements, traffic control, right-of-way, plotting of finished cross-sections, quantities, and other geometric design factors. We anticipate approximately 400 ft of approach roadway reconstruction will be required for this project.

10.2 If required, the Consultant shall prepare a Storm Water Pollution Prevention Plan (SWPPP).

10.3 The Consultant shall prepare a construction cost estimate and special provisions for the approach roadway construction.

10.4 The Consultant shall submit the plans and supporting documentation to the Client and MnDOT for review and approval.

11.0 CONSTRUCTION ENGINEERING

11.1 The Consultant will provide full-time construction observation, staking, and onsite materials (concrete) testing for this project. The duties for which the Consultant will be responsible include:

- Participating in the pre-con meeting
- Review of shop drawings
- Performing all necessary field staking
- Observing and documenting all construction activities as required by the Plans, Special Provisions, and MnDOT Standard Specifications for Construction
- Inspection of materials and testing of concrete (slump, air, cast cylinders) in accordance with the "Schedule for Materials Control"
- Documentation of all quantities in accordance with the MnDOT Contract Administration Manual – Section 5-591.400 Documentation through final project acceptance by MnDOT and McLeod County

11.2 The Consultant shall retain a competent firm, subject to the approval of the Client, to perform offsite materials testing (e.g., cylinder breaks, aggregate tests, etc.). *The testing firm will invoice the cost of this testing directly to the Client.*

C COMPENSATION

Compensation for the work described will be on a time and materials (Cost Plus) basis, which includes Erickson Engineering's profit.

Task, labor hours, and cost breakdowns have been prepared and are listed as follows. Table 1 shows Design Phase services and Table 2 shows Construction Phase services. The cost breakdowns are based on the assumption that the new bridge will be approximately 196 ft long, with a 28 ft wide roadway. There will also be approximately 400 ft of approach roadway reconstruction required (100 ft north approach and 300 ft south approach).

TABLE 1 - DESIGN PHASE

Engineering Services Cost Breakdown for Replacement of McLeod County Bridge 43001

Services / Rate	Engineering Manager $157.00	Senior Structural Engineer $122.00	Project Engineer $98.00	Drafting Manager $108.00	Engineering Technician II $85.00	Hours	Fee
Survey				*14*	*24*	38	$3,552.00
Hydraulics			*25*			25	$2,450.00
Preliminary Design - Structure Options			*4*			4	$392.00
Meetings	*6*					6	$942.00
Permit Applications			*6*			6	$588.00
Utility Coordination					*1*	1	$85.00
Bridge Design / Plans	*20*	*50*	*48*	*20*	*130*	268	$27,154.00
Special Provisions, Estimate, Load Rating, Checklist, Stool Heights			*16*			16	$1,568.00
Roadway Design / Plans			*32*		*50*	82	$7,386.00
Subtotal / Hours	26	50	131	34	205	**446**	**$44,117.00**
Asbestos Assessment (Carlson McCain)							$1,280.00
Soils Report (CVT)							$4,980.00
Wetland Delineation (If Necessary)							$2,500.00
TOTAL DESIGN PHASE (NOT-TO-EXCEED)							**$52,877.00**

TABLE 2 - CONSTRUCTION PHASE

Construction Engineering Services Cost Breakdown for Replacement of McLeod County Bridge 43001

Services	Rate	Survey Crew $190.00	Certified Inspector $88.00	Hours	Fee
Construction Staking, Observation, Testing (assumes approximately 70 working days for construction.		*16*	*630*	646	$58,480.00
Subtotal / Hours		16	630	**646**	**$58,480.00**
Lodging / Mileage					$4,800.00
TOTAL CONSTRUCTION PHASE (NOT-TO-EXCEED)					**$63,280.00**

Based on the above projections, the Consultant estimates that it can complete the work described for **$116,157.00** ($52,877.00 for the design phase and $63,280.00 for the construction phase). Therefore, the Consultant proposes to complete the work required on a time and materials basis using the rates shown, for a fee not-to-exceed **$116,157.00** unless prior approval has been received from the Client.

CONDITIONS AND PAYMENT SCHEDULE

The Consultant may request progress payments for “Cost Plus” services while the work is in progress, based on time and materials provided within a specific timeframe. The progress payments are due upon receipt of invoice.

Cancellation: If the Client cancels this agreement, the Consultant may request payment for all work performed up to the cancellation date. The Client shall pay for fully completed work as outlined above. The Consultant will invoice partially completed work on a Time and Materials basis, according to section E Time and Materials Rates. The total amount invoiced for the partially completed work will not exceed the amount which would have been due had the work been fully completed.

Additional Services: If the Client requests that the Consultant provide services not listed in this agreement, or if any additional services are required due to revisions in MnDOT, FHWA, AASHTO, or Client standards or specifications, then the Consultant may request reimbursement for such services. The Client shall pay the Consultant on a Time and Materials basis, according to section E Time and Materials Rates, unless otherwise agreed to in writing by both the Consultant and the Client.

D TIMELINE

TASK	COMPLETION DATE
Kick-off Meeting with County Staff	March 4, 2016
Survey	March 25, 2016
Hydraulic Analysis and Preliminary Design	April 15, 2016
Asbestos Assessment	April 29, 2016
Soils Report	April 29, 2016
Wetland Delineation (If Necessary)	June 17, 2016
Permits / Utility Coordination	May 16 , 2016
Submit Bridge / Roadway Plans (30% Complete)	May 16, 2016
Meeting with County to discuss 30% plan review comments	June 24, 2016
Submit Bridge / Roadway Plans (95% Complete)	October 21, 2016
Submit Final Bridge / Roadway Plans, Special Provisions, Estimate, Load Rating, Checklist	December 16, 2016
Construction Phase Services	Spring 2017

E TIME AND MATERIALS RATES

TITLE	RATE/HR
Vice President	$ 170.00
Engineering Manager	$ 157.00
Project Manager	$ 105.00 - $ 125.00
Project Engineer	$ 87.00 - $ 100.00
Design Engineer	$ 85.00
Drafting Manager	$ 108.00
Engineering Technician II	$ 85.00

TITLE	RATE/HR
Engineering Technician I	$ 77.00
Certified Inspector	$ 88.00
Mileage Rate	$ 0.54/mile

Rates may be adjusted annually to reflect cost of living increases.

F GENERAL CONDITIONS

I Scope of Professional Engineering Services

The Consultant agrees to provide the services described in section B Services when the Client requests and authorizes the Consultant to provide the services. The Client shall pay the Consultant for these services on a Time and Materials basis, at the rates stated in section E Time and Materials Rates, unless otherwise stated in this agreement.

II Responsibilities of the Consultant

The Consultant shall maintain Professional Liability Insurance for $2,000,000 (two million dollars) during the life of this contract. If the Client requests additional insurance, the Consultant will purchase such insurance if available. The Client will pay the cost of the additional insurance.

The Consultant is not responsible for the failure of others to perform in accordance with other contracts. The Consultant's services do not relieve others of their responsibilities.

III Responsibilities of the Client

The Client shall make available to the Consultant all known information applying to the site and services provided by the Consultant. The Client shall immediately inform the Consultant of new information which may be in conflict with previous information regarding the site or Consultant services. The Consultant has a right to depend on documents and information supplied by the Client.

IV Other Damages

The Consultant and the Client will not be liable to each other for any incidental, consequential, or special damage relating to the Consultant’s services. This includes business interruption, good will, or loss of anticipated profits.

V Termination

Either party may terminate this agreement by giving fourteen days written notice to the other party. Upon termination, the Client will pay the Consultant for costs incurred to the date of termination, including termination costs and other obligations and commitments incurred in

providing services. All obligations and liabilities between the parties will terminate upon payment. These costs are payable under the contract when invoiced.

VI Document Ownership

The Client acknowledges the Consultant's construction documents as instruments of professional service. Nevertheless, the plans and specifications prepared under this Agreement will become the property of the Client upon completion of the work and payment in full of all monies due to the Consultant. The Client shall not reuse or make any modification to the plans and specifications without the prior written authorization of the Consultant. To the fullest extent permitted by law, the Client agrees to indemnify and hold the Consultant harmless from any claim, liability or cost (including reasonable attorney's fees and defense costs) arising or allegedly arising out of unauthorized reuse or modification of the construction documents by the Client, or by any person or entity that obtains the plans and specifications from or through the Client, without written authorization of the Consultant.

VII Party Relationship

The Consultant shall act solely as an independent contractor. The Client and the Consultant may not enter into any agreement or assume any obligation for the other.

VIII Force Majeure

The Consultant shall not be liable for failure to perform due to circumstances beyond the Consultant's control. These may include, but are not limited to, wars, floods, strikes, riots, fire, acts of nature, or inability to obtain equipment or material. In the event of such circumstances, the Client will agree to extend the performance time sufficiently to overcome the effects of such events.

IX Successors and Assigns

The Consultant and Client each binds itself, its successors, and assigns to the other party of this agreement and to the successors and assigns of the other party with respect to all provisions of this agreement.

X Entire Agreement

This agreement represents the entire understanding between the Client and the Consultant. No change of the terms or conditions of this agreement will be binding on either party unless these changes are in writing and signed by an authorized representative of both parties.

XI Applicable Law

The laws of the State of Minnesota will govern this agreement.

XII AA/EEO

The Consultant is an Affirmative Action and Equal Employment Opportunity Employer.

XIII Dispute Resolution

In the event of a dispute arising out of or relating to this Agreement or the services the Consultant renders or will render hereunder, the Client and Consultant agree to attempt to resolve such disputes in the following manner:

First, the parties agree to attempt to resolve such disputes through direct negotiations between the appropriate representatives of each party.

Second, if such negotiations are not fully successful, the parties agree to attempt to resolve any remaining dispute by formal non-binding mediation, conducted according to rules and procedures agreed upon by the parties, unless the parties mutually agree otherwise.

Third, if the dispute or any issues remain unresolved after the above steps, the parties agree to allow the mediator to help select an alternative resolution method.

G AUTHORIZATION

The Client and the Consultant agree as set forth above.

For the Client:

McLeod County Highway Department
1400 Adams St SE
Hutchinson, MN 55350

_____
Signature

_____
Title

_____
Date

_____
Signature

_____
Title

_____
Date

For the Consultant:

Erickson Engineering Co., LLC
9330 James Ave S
Bloomington, MN 55431

Thomas J. Wilson
Thomas J. Wilson, P.E.

Vice President
Title

February 9, 2016
Date

STATE OF MINNESOTA
PRICING PAGE

Price quote for: **TANDEM AXLE CAB/CHASSIS**

Vendor Name:	**NUSS TRUCK & EQUIPMENT**
Contact Person:	**BOB PROW**
Street Address:	**2195 WEST COUNTY ROAD C2**
P.O. Box:	
City, State, Zip	**ROSEVILLE, MN 55113**
Phone #:	**651-633-4810**
Toll Free #:	**800-704-0935**
Fax #:	**651-635-0928**
Email Address:	**bprow@nussgrp.com**

Version of Excel used: **2010**

Spec #	Information Requested	Answer
1.0	Make & Model	2016 MACK SFA GU713
	C.A. & W.B. dimension	210" WB, 123" CA
	Front Axle Location (Set Forward, Set Back)	Set Forward
	Frame, Steel PSI	120,000 PSI
	Frame, Section Modulus	17.7 SM
	Frame, Resistance to Bending Moment	2,120,000 RBM
	Frame overhang length	62" AF
	Type of fasteners used on frame members	Huck
	Front bumper description	Swept Back Steel
	Front Axle Type & Size	Mack FXL12, 12,000 lbs.
	Front Spring length	55"
	Front brake size	16.5" x 5" Bendix ES165-05D
	Front Brake chamber size	24"
	U Joint Make, Model & Type (1/2 round, etc.)	Meritor 17 MXL Extended Life
	Rear Axle Type & Size	Mack SS38, 38,000 lbs.
	Rear brake size	16.5" x 7" Bendix ES165-07D
	Rear brake chamber size	30/30

STATE OF MINNESOTA

PRICING PAGE

Spec #	Information Requested	Answer
	Parking Brake Type & Model #	Haldex/Anchorlok
	Front Tire Make & Size	11R22.5 14 Ply Bridgestone R250
	Front Rim Size & Rating	22.5 x 8.25 7,800 lbs
	Rear tire make & size	11R22.5 14 PLY Bridgestone M726EL
	Rear rim size & rating	22.5 X 8.25 7,800 LBS
	Air compressor type & size	Meritor/Wabco 18.7 CFM
	Air dryer info	Meritor 1200
	Engine type, HP & torque	Mack MP7-325M - 325HP @ 1500 - 1900 RPM 1200/LB/FT Max Torque
	Type of engine fan drive	Behr Fan And Electronic Modulating Fan Drive
	Exhaust description	Diesel Particulate Filter RH Side under Cab with SCR Frame Mounted RH Side
	Starter motor Make & Model	Delco 39MT-MXT
	Right side steering assist (Auxiliary gear, hydraulic ram or none)	None
	Transmission Make & Model, # of Speeds	Mack TM310 10 Speed
	Clutch size and # of plates	15.5" Two Plate
	Battery CCA, # of batteries, CCA of each battery	Three Mack 650/1950 CCA
	Fuel tank size, shape and material	50 Gallon LH Steel 22" Dia
	Alternator Type & Size	Delco 12V 130A (24SI Brush Type)
	Radiator Sq in & Material	Aluminum Core
	Type and number of horns	One Mack Rectangle Air
	Cab ride (type of mounting)	Air Ride Cab
	Cab size door to door, floor to ceiling	78", 62"
	Distance of cab floor from ground	47"
	Description of seats supplied with base cab & chassis	Bostrum Talladaga 915 Mid-Back Air Driver Seat, Fixed Mack Mid-Back Passenger Seat
	Windshield washer nozzle location	Mounted on Wiper Arm

STATE OF MINNESOTA

PRICING PAGE

Spec #	Information Requested	Answer
	Interior package (Low, Med or Premium)	Purebred - Low
	Does unit include cruise control	Yes
	How is dome light activated	Door & Cab Switch
	Steering wheel adjustment (tilt, telescoping, etc)	Tilt & Telescoping
	Cab grab handle locations	RH & LH Behind Door
	Storage pocket description	Two Storage Compartment & Net Retainers with Center Mounting for CB Provisions
	Cab Gauges, List	Air Pressure, Voltmeter, Engine Coolant Temperature, Engine Oil Pressure, Speedometer, and Tachometer, Exhaust Pyrometer, and Tranwmission Oil Temperature
	Dimmer switch location	Turn Signal
	Paint description	Mack White
	Cab & chassis warranty (time & mileage)	One Year or 100,000 Miles
	Engine warranty (time & mileage)	Two Years or 250,000 miles
	Transmission warranty (time & mileage)	Mack - Five Years or 500,000 Miles
	Rear end warranty (time & mileage)	Mack - Five Years or 500,000 Miles
	Delivery of chassis starting point	Roseville, MN 55113
	Estimated weight on front axle for base unit	8,421
	Estimated weight on Rear axle for base unit	8,077

Print Date & Time 2/10/2016 9:42

Tandem Axle Cab & Chassis

VENDOR NAME NUSS TRUCK & EQUIPMENT

MAKE AND MODEL MACK GU713 AF TANDEM

This section for use when ordering

WB	212"
CA	126"
AF	62"
Rear Ratio	4.11
Cab Color	FLAME RED
Wheel Color	WHITE
Note	MCLEOD COUNTY

Grand Total $ 116,579.00

UPDATED 1-12-16

Spec #	Description	Qty	Price	Subtotal
1.0	Price for Base Unit:	1	$ 80,286.00	$ 80,286.00
2.0	**FRAME OPTIONS**			
2.1	Front frame extension	1	$ 848.00	$ 848.00
2.2	Custom hole punching in frame		$ 150.00	$ -
2.3	Deduct for no front bumper	1	$ (10.00)	$ (10.00)
2.4	Frame fastener option (bolt or huck spun)	1	STD	
2.5	**Frame, R.B.M., S.M., PSI, CT**			
2.6	2,120,000 17.7 120,000 87 - 112 CA		$ (70.00)	$ -
2.7	2,120,000 17.7 120,000 113 - 133 CA		STD	
2.8	2,120,000 17.7 120,000 134 - 152 CA		$ 102.00	$ -
2.9	2,120,000 17.7 120,000 153 - 199 CA		$ 216.00	$ -
2.10	2,120,000 17.7 120,000 200 - 236 CA		$ 314.00	$ -
2.11	2,470,000 20.6 120,000 87 - 112 CA		$ 154.00	$ -
2.12	2,470,000 20.6 120,000 113 - 133 CA		$ 240.00	$ -
2.13	2,470,000 20.6 120,000 134 - 152 CA		$ 337.00	$ -
2.14	2,470,000 20.6 120,000 153 - 199 CA		$ 436.00	$ -
2.15	2,470,000 20.6 120,000 200 - 236 CA		$ 534.00	$ -
2.16	2.820,000 23.5 120,000 87 - 112 CA		$ 473.00	$ -
2.17	2.820,000 23.5 120,000 113 - 133 CA	1	$ 558.00	$ 558.00
2.18	2.820,000 23.5 120,000 134 - 152 CA		$ 655.00	$ -
2.19	2.820,000 23.5 120,000 153 - 199 CA		$ 754.00	$ -
2.20	2.820,000 23.5 120,000 200 - 236 CA		$ 852.00	$ -
2.21	3,160,000 26.3 120,000 87 - 112 CA		$ 650.00	$ -
2.22	3,160,000 26.3 120,000 113 - 133 CA		$ 737.00	$ -
2.23	3,160,000 26.3 120,000 134 - 152 CA		$ 833.00	$ -
2.24	3,160,000 26.3 120,000 153 - 199 CA		$ 932.00	$ -
2.25	3,160,000 26.3 120,000 200 - 236 CA		$ 1,030.00	$ -
	DOUBLE FRAME - PARTIAL IC REINFORCEMENT			
2.26	3,230,000 26.9 120,000 87 - 112 CA		$ 411.00	$ -
2.27	3,230,000 26.9 120,000 113 - 133 CA		$ 497.00	$ -
2.28	3,230,000 26.9 120,000 134 - 152 CA		$ 595.00	$ -
2.29	3,230,000 26.9 120,000 153 - 199 CA		$ 693.00	$ -
2.30	3,230,000 26.9 120,000 200 - 236 CA		$ 791.00	$ -
2.31	3,580,000 29.8 120,000 87 - 112 CA		$ 631.00	$ -

Spec #	Description	Qty	Price	Subtotal
2.32	3,580,000 29.8 120,000 113 - 133 CA		$ 717.00	$ -
2.33	3,580,000 29.8 120,000 134 - 152 CA		$ 814.00	$ -
2.34	3,580,000 29.8 120,000 153 - 199 CA		$ 913.00	$ -
2.35	3,580,000 29.8 120,000 200 - 236 CA		$ 1,011.00	$ -
2.36	3,920,000 32.7 120,000 87 - 112 CA		$ 949.00	$ -
2.37	3,920,000 32.7 120,000 113 - 133 CA		$ 1,035.00	$ -
2.38	3,920,000 32.7 120,000 134 - 152 CA		$ 1,132.00	$ -
2.39	3,920,000 32.7 120,000 153 - 199 CA		$ 1,232.00	$ -
2.40	3,920,000 32.7 120,000 200 - 236 CA		$ 1,329.00	$ -
2.41	4,260,000 35.5 120,000 87 - 112 CA		$ 1,127.00	$ -
2.42	4,260,000 35.5 120,000 113 - 133 CA		$ 1,213.00	$ -
2.43	4,260,000 35.5 120,000 134 - 152 CA		$ 1,310.00	$ -
2.44	4,260,000 35.5 120,000 154 - 199 CA		$ 1,409.00	$ -
2.45	4,260,000 35.5 120,000 200 - 236 CA		$ 1,506.00	$ -
	DOUBLE FRAME - FULL IC REINFORCEMENT			
2.46	3,230,000 26.9 120,000 87 - 112 CA		$ 662.00	$ -
2.47	3,230,000 26.9 120,000 113 - 133 CA		$ 748.00	$ -
2.48	3,230,000 26.9 120,000 134 - 152 CA		$ 845.00	$ -
2.49	3,230,000 26.9 120,000 153 - 199 CA		$ 944.00	$ -
2.50	3,230,000 26.9 120,000 200 - 236 CA		$ 1,042.00	$ -
2.51	3,580,000 29.8 120,000 87 - 112 CA		$ 883.00	$ -
2.52	3,580,000 29.8 120,000 113 - 133 CA		$ 968.00	$ -
2.53	3,580,000 29.8 120,000 134 - 152 CA		$ 1,065.00	$ -
2.54	3,580,000 29.8 120,000 153 - 199 CA		$ 1,164.00	$ -
2.55	3,580,000 29.8 120,000 200 - 236 CA		$ 1,262.00	$ -
2.56	4,260,000 35.5 120,000 87 - 112 CA		$ 1,299.00	$ -
2.57	4,260,000 35.5 120,000 113 - 133 CA		$ 1,446.00	$ -
2.58	4,260,000 35.5 120,000 134 - 152 CA		$ 1,606.00	$ -
2.59	4,260,000 35.5 120,000 153 - 199 CA		$ 1,205.00	$ -
2.60	4,260,000 35.5 120,000 200 - 236 CA		$ 2,009.00	$ -
	TRIPLE FRAME - FULL IC REINFORCEMENT			
2.61	5,688,000 47.4 120,000 87 - 112 CA		$ 3,815.00	$ -
2.62	5,688,000 47.4 120,000 113 - 133 CA		$ 3,900.00	$ -
2.63	5,688,000 47.4 120,000 134 - 152 CA		$ 3,896.00	$ -
2.64	5,688,000 47.4 120,000 153 - 199 CA		$ 4,096.00	$ -
2.65	5,688,000 47.4 120,000 200 - 236 CA		$ 4,194.00	$ -
2.66	Flush bright finish channel steel		$ 109.00	$ -
2.67	Extended stylized-silver-bright finish steel w/stone guard		$ 1,439.00	$ -
2.68	Extended stylized-silver-painted steel w/stone guard		$ 1,141.00	$ -
2.69	Extended - swept back steel with stone guard - includes center tow pin		$ 774.00	$ -
2.70	Extended - swept back steel, bright finish with stone guard - includes center tow pin		$ 1,095.00	$ -
2.71	Mill finish, flush mounted, unpainted aluminum		$ 66.00	$ -
2.72	Stainless steel clad aluminum flush mounted		$ 324.00	$ -
2.73	Extended swept back channel steel with bright finish w/painted		$ 596.00	$ -
2.74	Extended swept back steel channel w/bright finish		$ 248.00	$ -
2.75	Extended swept back painted steel		STD	
2.76	Plate type radiator guard		$ 101.00	$ -

Spec #	Description	Qty	Price	Subtotal
2.77	Bright finish plate type radiator guard		$ 248.00	$ -
2.78	Tectyl 185 GW pigmented compound between frame rails		$ 110.00	$ -
3.0	**FRONT AXLE/SUSPENSION/BRAKE/OPTION**			
3.1	Set forward front axle option	1	STD	
3.2	14,600 front axle & matching suspension - Mack FXL14.6		$ 742.00	$ -
3.3	16,000 front axle and matching suspension - Mack FXL18		$ 1,347.00	$ -
3.4	18,000 front axle and matching suspension - Mack FXL18		$ 1,336.00	$ -
3.5	20,000 front axle and matching suspension - Mack FXL20	1	$ 2,471.00	$ 2,471.00
3.6	23,000 front axle and matching suspension - Mack FXL23		$ 2,712.00	$ -
3.7	Heavy duty front axle shocks	1	STD	
3.8	Front brake dust shields	1	$ 17.00	$ 17.00
3.9	Dual front auxiliary steering gear		$ 857.00	$ -
3.10	RH spring build up for wing plow application		$ 25.00	$ -
3.11	LH spring build up for wing plow application		$ 25.00	$ -
3.12	All wheel drive front axle		$ 43,000.00	$ -
3.13	Twin Steer Front Axle		$ 10,251.00	$ -
3.14	Aluminum front hubs		$ 51.00	$ -
3.15	Centerfuse outboard mounted brake drums		$ 209.00	$ -
3.16	Multileaf front spring ILO taperleaf (2 leaf spring)		$ 34.00	$ -
3.17	HD mulitileaf front spring ILO taperleaf (2 leaf spring)		$ 63.00	$ -
3.18	HD taperlead (3 leaf spring) ILO of taperleaf (2 leaf spring)		$ 63.00	$ -
3.19	Air Disc Brakes requires Meritor rear brakes		$ 1,486.00	$ -
3.20	Meritor front slack adjustors - Need same slack on rear axle		$ 1.00	$ -
3.21	Haldex front slack adjustors - Need same slack adjustor on rear axle	1	STD	
3.22	Meritor front brakes - Need to match same brakes with rear axle		$ 126.00	$ -
4.0	**4.0 TANDEM REAR AXLE/SUSPENSION/BRAKE/OPTIONS**			
4.1	46,000# rear axle & matching suspension Make & Model - Mack SS462 Mack Camelback Suspension		$ 2,334.00	$ -
4.2	40,000# walking beam rear suspension and axle Make & Model - Meritor MT-40-14X4D with Hendrickson HMX400		$ 2,148.00	$ -
4.3	46,000# walking beam rear suspension and axl Make & Model - Meritor RT-46-160 with Hendrickson HMX460		$ 4,407.00	$ -
4.4	40,000# air suspension and axle Make & Mode Meritor MT-40-14X4D with Mack AL461 46,000 lbs air suspension		$ 1,037.00	$ -
4.5	46,000# air suspension and axle Make & Mode Meritor RT-46-160 with Mack AL461 46,000 lbs air suspension		$ 2,833.00	$ -
4.6	Dash mounted air dump system - With air ride suspension		STD	
4.7	Driver activated differential lock on one rear axle (front axle ____ rear axle ____, check one)		$ 466.00	$ -
4.8	Driver activated differential lock on both front and rear axles		$ 931.00	$ -
4.9	Driver activated differential lock on both front and rear axles, and lubrication pump and filter system		$ 1,077.00	$ -
4.10	Meritor MT-40-14X4DP, both axles driver differential lock and pump, HMX400 40,000 # walking beam suspension	1	$ 3,225.00	$ 3,225.00
4.11	Meritor RT-46-160P, both axles driver differential lock and pump, HMX460 46,000 # walking beam suspension		$ 5,484.00	$ -
4.12	½ round universal joints	1	STD	
4.13	Spicer 1810 HD drive line with half round universal joints		$ 96.00	$ -

Spec #	Description	Qty	Price	Subtotal
4.14	Rear Dust Shields	1	$ 32.00	$ 32.00
4.15	Meritor 18 MXL extended lube	1	$ 30.00	$ 30.00
4.16	Meritor 176 MXL extended lube		$ 20.00	$ -
4.17	Mack S402R with mRide 40,000 Lbs suspension with normal stiffness 2-lef parabolic (taper-leaf) springs		$ 2,811.00	$ -
4.18	Mack S402R with mRide 40,000 Lbs suspension with stiffer than normal 3-leaf parabolic (taper-leaf) springs		$ 2,917.00	$ -
4.19	Mack S462R with mRide 46,000 Lbs suspension with normal stiffness 3-leaf parabolic (taper-leaf) springs		$ 3,315.00	$ -
4.20	Meritor MT-40-14X4D with mRide 40,000 lbs suspension with normal stiffness 2- leaf parabolic (taper-leaf) springs		$ 1,122.00	$ -
4.21	Meritor MT-40-14X4D with mRide 40,000 lbs suspension with stiffer than noral 3-leaf parabolic (taper-leaf) springs		$ 1,554.00	$ -
4.22	Mack SSB38, Mack Camelback with boost-a-load		$ 951.00	$ -
4.23	Mack SAL38 with Mack AL-402 air suspension		$ 993.00	$ -
4.24	Mack SB38 with Henrickson HMX460 suspension		$ 3,149.00	$ -
4.25	Mack SWB38, 38,000 lbs walking beam		$ 1,531.00	$ -
4.26	Mack SB38 with Chalmers 46,000 # L High Stability		$ 3,607.00	$ -
4.27	Mack SSB38, Mack Camelback 40,000 lbs recertification		$ 950.00	$ -
4.28	Mack SS440, Mack 44,000 lbs camelback suspension		$ 1,615.00	$ -
4.29	Mack SW440, Mack 44,000 lbs walking beam		$ 1,859.00	$ -
4.30	Mack SAL440 with Mack AL-461 air suspension		$ 1,906.00	$ -
4.31	Mack SS440, Mack 44,000 lbs camelback suspension 46,000 lbs recertification		$ 1,896.00	$ -
4.32	Mack S462 with Hendrickson HMX460 46,000 lbs		$ 3,607.00	$ -
4.34	Mack S462 with Hendrickson HN462 46,000 lbs walking beam		$ 3,311.00	$ -
4.35	Mack S462 with Hendrickson RS460 46,000 lbs walking beam/rubber HD load cushion		$ 3,345.00	$ -
4.36	Dana-Spicer DS405 with Hendrickson HMX400 40,000 lbs suspension		$ 2,388.00	$ -
4.37	Dana-Spicer DS405P with Hendrickson HMX400 40,000 lbs suspension		$ 2,529.00	$ -
4.38	Dana-Spicer D46-170HP with Hendrickson HMX460 46,000 lbs suspension		$ 5,532.00	$ -
4.39	Dana-Spicer D46-170HP with Mack AL-461 46,000 lbs air suspension		$ 4,325.00	$ -
4.40	Dana-Spicer D46-170HP with Hendrickson HN462 suspension		$ 4,555.00	$ -
4.41	Dana-Spicer D46-170HP with Chalmers 46,000 lbs L High Stability		$ 5,534.00	$ -
4.42	Meritor RT-46-160 with Chalmers 46,000 lbs L High Stability suspension		$ 4,600.00	$ -
4.43	Meritor RT-46-164EH with Hendrickson HMX460 46,000 lbs suspension		$ 4,754.00	$ -
4.44	Meritor RT-46-164EH w/ Chalmers 46,000 lbs L High Stability		$ 4,825.00	$ -
4.45	Meritor RT-46-164EH with Mack AL-461 46,000 lbs air suspension		$ 3,077.00	$ -
4.46	Mack 200 carriers		$ 726.00	$ -
4.47	Mack 150/151 carriers with interwheel		$ 2,642.00	$ -
4.48	Mack 200 carriers with interwheel		$ 3,497.00	$ -
4.49	Mack power dividier		$ 205.00	$ -
4.50	Transverse torque rod - Mack suspension only		$ 148.00	$ -
4.51	Aluminum rear hubs		$ 35.00	$ -
4.52	Centerfuse outboard brake drums		$ 198.00	$ -

Spec #	Description	Qty	Price	Subtotal
4.53	Meritor rear slack adjustors		$ 1.00	$ -
4.54	Haldex rear slack adjustors	1	STD	
4.55	Dana-spicier SPL170XL extended lube series		$ 279.00	$ -
4.56	Dana-spicier SPL250XL extended lube series		$ 300.00	$ -
4.55	Dana-spicier SPL250HDXL extended lube series		$ 381.00	$ -
4.56	HD rear shock absorbers for rear axle	1	$ 67.00	$ 67.00
4.57	Trac Tech no spin		$ 1,825.00	$ -
4.58	Scotseal longlife rear oil seals		$ 56.00	$ -
4.59	Stemco-Grit Guard rear oil seals rear oil seals		$ 61.00	$ -
4.60	Heavy duty shock insulators for Mack rear axle		$ 133.00	$ -
4.61	Haldex "Gold Seal" spring brake chambers		$ 18.00	$ -
4.62	MGM MDL TR-T (Tamper resistant brake chamber) reclock inlet ports for optimum ground clearanc3		$ 67.00	$ -
4.63	Haldex "life seal" spring brake chamber		$ 1.00	$ -
4.64	30/36 spring brake chambers - requires MGM model TRT spring brake chambers		$ 51.00	$ -
4.65	Air Disc Brake (17") H-Type - Require Air Disc Front Brakes & M-Ride 3 leaf suspension		$ 2,622.00	$ -
4.66	Bendix ES165-08D, 16.5" x 8 5/8" Cast Spidier - Require M-Riode suspension. N/A with dust shields		$ 260.00	$ -
4.67	Meritor rear brakes - 16.5"7" Q+		$ 111.00	$ -
4.68	Meritor rear brakes - 16.5" x 8 5/8+ Q+ - N/A with dust shields		$ 287.00	$ -
4.69	13,500 lbs Hendrickson steerable composilite HLUS-2 pusher axle - includes tires and rims		$ 9,791.00	$ -
4.70	10,000 lbs Hendrickson steerable composilite HLUS-2 pusher axle - includes tires and rims		$ 9,791.00	$ -
4.71	20,000 lbs Watson-Chalin steerable SL-2089 Thu Track Series pusher axle - includes tire and rims		$ 12,381.00	$ -
4.72	13,200 lbs Watson-Chalin steerable SL-1187 Thu Track Series pusher axle - includes tire and rims		$ 10,173.00	$ -
4.73	20,000 lbs Watson-Chalin non-steerable AL-2200 Atlas Series pusher axle - includes tire and rims		$ 9,198.00	$ -
4.74	20,000 lbs Hendrickson non - steerable composilite HLM pusher axle - includes tires and rims		$ 9,091.00	$ -
4.75	13,200 lbs Hendrickson steerable HLUS2Z pusher axle - includes tires and rims		$ 9,791.00	$ -
4.76	20,000 lbs Hendrickson Paralift HLP20 steerable pusher axle - includes tires and rims		$ 11,192.00	$ -
4.77	13,500 lbs Hendrickson steerable composilite HLUS-2 tag axle - includes tires and rims		$ 9,791.00	$ -
4.78	10,000 lbs Hendrickson steerable composilite HLUS-2 tag axle - includes tires and rims		$ 9,791.00	$ -
4.79	20,000 lbs Watson-Chalin steerable SL-2089 Thu Track Series tag axle - includes tire and rims		$ 12,381.00	$ -
4.80	13,200 lbs Watson-Chalin steerable SL-1187 Thu Track Series tag axle - includes tire and rims		$ 10,173.00	$ -
4.81	20,000 lbs Watson-Chalin non-steerable AL-2200 Atlas Series tag axle - includes tire and rims		$ 9,198.00	$ -
4.82	20,000 lbs Hendrickson non - steerable composilite HLM tag axle - includes tires and rims		$ 9,091.00	$ -
4.83	13,200 lbs Hendrickson steerable HLUS2Z tag axle - includes tires and rims		$ 9,791.00	$ -
4.84	20,000 lbs Hendrickson Paralift HLP20 steerable tag axle - includes tires and rims		$ 11,192.00	$ -
4.85	6S/6M systems sensing both rear axle wheel end sensors		$ 423.00	$ -

Spec #	Description	Qty	Price	Subtotal
4.86	Furnish Meritor wide track axle option - Need for Super Singles		$ 983.00	$ -
5.0	**Fifth Wheel options**			
5.1	Frame end tapered and closed		$ 30.00	$ -
5.2	Fixed fifth wheel - Holland FW-35		$ 915.00	$ -
5.3	Mechanical slide fifth wheel - Fontaine SL6MWS Travel - 24" slide		$ 1,535.00	$ -
5.4	Air operated slide fifth wheel - Holland FW35 Travel 24" slide		$ 1,200.00	$ -
5.5	Stainless 1/4 fenders, mounted front of tandems		$ 138.00	$ -
5.6	Plastic 1/4 fenders, mounted front of tandems		$ 84.00	$ -
5.7	Tractor package hookup		$ 285.00	$ -
5.8	Behind cab deck plate		$ 655.00	$ -
5.9	Holland fixed with non-tilt 5th wheel		$ 1,599.00	$ -
5.10	Holland manual slide 5th wheel			$ -
5.11	Mack mud flaps with brackets		$ 59.00	$ -
5.12	Hose tender & towel bar assembly		$ 47.00	$ -
5.13	Coiled trailer air hose		$ 27.00	$ -
5.14	Coiled trailer electrical hose		$ 27.00	$ -
6.0	**TIRES/RIMS OPTIONS:**			
6.1	Nylon wafers or wheel guards on all wheels (6 ea)	1	$ 43.00	$ 43.00
6.2	Heavier 7500 lb 22.5 x 8.25 Steel rims in lieu of standard 7300# rims (10 ea)		STD	
6.3	Heavier 7500 lb 22.5 x 8.25 Steel rims in lieu of standard 7300# rims (8 ea) in rear only	1	STD	
6.4	11R 22.5 H front tires		$ 106.00	$ -
6.5	12R 22.5 H front tires		$ 228.00	$ -
6.6	9000 lb 22.5 9” front steel rims, 315/80R 22.5 J front tires		$ 461.00	$ -
6.7	10,000 lb 22.5 9” front steel rims, 315/80R 22.5 J front tires		$ 493.00	$ -
6.8	10,500 lb 22.5 x 12.25 front steel rims, 385/65R 22.5 J front tires	1	$ 769.00	$ 769.00
6.9	10,500 lb 22.5 x 12.25 front steel rims, 425/65R 22.5 J front tires		$ 823.00	$ -
6.10	11R 22.5 H rear tires		$ 88.00	$ -
6.11	7,300 lb 24.5” x 8.25” steel front rims		$ 88.00	$ -
6.12	7300 lb 24.5” x 8.25” rear steel rims		$ 138.00	$ -
6.13	8,000 lb 24.5” x 8.25" steel front rims		$ 103.00	$ -
6.14	8,000 lb 24.5” x 8.25” steel rear rims		$ 186.00	$ -
6.15	11R 24.5 G front tires		$ 46.00	$ -
6.16	11R 24.5 H front tires		$ 56.00	$ -
6.17	11R 24.5 G rear tires		$ 286.00	$ -
6.18	11R 24.5 H rear tires		$ 1,892.00	$ -
6.19	Steel spare rim, size 22.5 x 8.25		$ 175.00	$ -
6.20	Streel spare rim, size 24.5 x 8.25		$ 185.00	$ -
6.21	Steel spare rim, size 22.5 x 9.0		$ 370.00	$ -
6.22	Steel spare rim, size 22.5 x 12.25		$ 470.00	$ -
6.23	12R22.5 H front tires		$ 639.00	$ -
6.24	12R 22.5 H rear tires		$ 2,032.00	$ -
6.25	Wheel lugwrench - includes handle		$ 47.00	$ -
6.26	Aluminum front wheel - 22.5 x 8.25		$ 123.00	$ -
6.27	Aluminum front wheel - 24.5 x 8.25		$ 144.00	$ -
6.28	Aluminum front wheel - 22.5 x 9.0		$ 373.00	$ -

Spec #	Description	Qty	Price	Subtotal
6.29	Aluminum front wheel - 22.5 x 12.25		$ 422.00	$ -
6.30	Polished aluminum front wheel		$ 47.00	$ -
6.31	Dura-bright bright finish front wheels		$ 197.00	$ -
6.32	Aluminum rear wheels - 22.5 x 8.25		$ 514.00	$ -
6.33	Aluminum rear wheels - 24.5 x 8.25		$ 599.00	$ -
6.34	Polished aluminum rear wheel four outboard of dual wheels		$ 127.00	$ -
6.35	Polished aluminum rear wheel all eight (8) wheels		$ 255.00	$ -
6.36	Dura-bright bright finish on all eight (8) rear wheels		$ 1,283.00	$ -
6.37	Dura-bright bright finish on all four (4) outboard rear wheels		$ 642.00	$ -
7.0	**BRAKE SYSTEM OPTIONS:**			
7.1	Wabco System Saver 1200 E heated air dryer	1	STD	
7.2	Manual cable drain valves on air tanks		$ 23.00	$ -
7.3	Auto drain valves on air tanks	1	$ 30.00	$ 30.00
7.4	MGM type TR-T rear brake chambers	1	$ 51.00	$ 51.00
7.5	S.S. pins on slack adjuster yoke (2 ea per yoke) For all air brake chambers	1	$ 123.00	$ 123.00
7.6	Inverted rear brake chamber mounting in lieu of regular mounting		$ 10.00	$ -
7.7	Relocate air dryer		$ 200.00	$ -
7.8	Bendix AD9 heated air dryer		$ 114.00	$ -
7.9	Bendix AD-IP heated air dryer		$ 158.00	$ -
7.10	Meritor/Wabco system twin heated air dryer		$ 519.00	$ -
7.11	Auto heated drain valve		$ 40.00	$ -
7.12	Aluminum air reservoirs		$ 185.00	$ -
7.13	Polished aluminum air reservoirs		$ 242.00	$ -
7.14	Increase air capacity for installation of extra axles		$ 267.00	$ -
7.14	Meritor/Wabco ABS system w/o automatic traction control		$ 133.00	$ -
7.15	Bendix ABS system with traction control		$ 281.00	$ -
7.16	Meritor/Wabco ABS system w/auto traction control		$ 364.00	$ -
7.17	Lanyard control on supply wet tank		$ 17.00	$ -
8.0	**ENGINE/EXHAUST AND FUEL TANKS OPTIONS: (List Make & Model, H.P., torque of engine and exhaust and fuel tank options)**			
8.1	Mack MP7-345A, 345 HP @ 1500 - 1700 RPM, 1360 LB FT Max Torque @ 1100 - 1300 RPM		$ 389.00	$ -
8.2	Mack MP7-345C, 345 HP @ 1500 - 1700 RPM, 1360 LB FT Max Torque @ 1100 - 130 RPM		$ 415.00	$ -
8.3	Mack MP7-365C, 365 HP @1500 - 1700 RPM, 1460 LB FT Max Torque @ 1100 - 1200 RPM		$ 783.00	$ -
8.4	Mack MP7-395C, 395 HP @ 1500 - 1700 RPM, 1560 LB FT Max Torque @ 1100 - 1200 RPM		$ 1,188.00	$ -
8.5	Mack MP7-325M, 325 HP @ 1500 - 1900 RPM, 1200 LB FT Max Torque @ 1100 - 1300 RPM		STD	
8.6	Mack MP7-365M, 365 HP @ 1500 - 1900 RPM, 1340 LB FT Max Torque @ 1100 - 1300 RPM		$ 734.00	$ -
8.7	Mack MP7-405M, 405 HP @ 1500 - 1900 RPM, 1480 LB FT Max Torque @ 1100 - 1300 RPM		$ 1,284.00	$ -
8.8	Mack MP8-415C, 415 HP @ 1500 - 1700 RPM, 1660 LB FT Max Torque @ 1100 - 1300 RPM		$ 2,566.00	$ -
8.9	Mack MP8-445C, 445 HP @ 1500 - 1760 RPM, 1760 LB FT Max Torque @ 1100 - 1300 RPM		$ 3,110.00	$ -

Spec #	Description	Qty	Price	Subtotal
8.10	Mack MP8-505C, 505 HP @ 1500 - 1700 RPM, 1760 LB FT Max Torque @ 1100 - 1500 RPM		$ 4,229.00	$ -
8.11	Mack MP8-425M, 425 HP @ 1500 - 1900 RPM, 1570 LB FT Max Torque @ 1100 - 1300 RPM	1	$ 2,744.00	$ 2,744.00
8.12	Mack MP8-455M, 455 HP @ 1500 - 1900 RPM, 1650 LB FT Max Torque @ 1100 - 1300 RPM		$ 3,231.00	$ -
8.13	Mack MP8-505M, 505 HP @ 1500 - 1900 RPM, 1760 LB FT Max Torque @ 1100 - 1500 RPM		$ 4,370.00	$ -
8.14	Clear Back of Cab - DPF & SCR Frame Mounted , RH Side under Cab	1	$ 663.00	$ 663.00
8.15	No Muffler, Single (R/S) Vertical Exhaust Cab Mounted, Lower Venturi Diffuser, Turned End		$ 241.00	$ -
8.16	No Muffler, Single (R/S) Vertical Exhaust Cab Mounted, Lower Venturi Diffuser, Plain End		$ 241.00	$ -
8.17	Single (R/S) Vertical Straight Exhaust Stack Plain End		$ (22.00)	$ -
8.18	Single (R/S) Vertical Straight Exhaust Stack Turned Out	1	STD	
8.19	Single (R/S) Vertical Straight Exhaust Stack Plain End Perf Stack		$ 31.00	
8.20	Single (R/S) Vertical Straight Exhaust Stack Plain End Side Outlet		$ 121.00	$ -
8.21	Single (R/S) Vertical Straight Exhaust Stack Plain Top Outlet Deffuser		$ 121.00	$ -
8.22	Dual Vertical Straight Exhaust Stack Plain End - N/A with Allison		$ 1,025.00	$ -
8.23	Dual Vertical Straight Exhaust Stack Turned Out End - N/A with Allison Transmission		$ 1,050.00	$ -
8.24	Dual Vertical Straight Exhaust Stack Plain Side Outlet Deffuser - N/A with Allison Transmission		$ 1,449.00	$ -
8.25	Dual Vertical Straight Exhaust Stack Plain Top Outlet Deffuser - N/A with Allison Transmission		$ 1,449.00	$ -
8.26	Single, Bright finish heat shield & stack	1	$ 63.00	$ 63.00
8.27	Dual, Bright finish heat shield & stack		$ 125.00	$ -
8.28	Single, Bright finish heat shield, stack & elbow		$ 156.00	$ -
8.29	Dual, Bright finish heat shield, stack & elbow		$ 331.00	$ -
8.30	Single, Bright finish stack only		$ 48.00	$ -
8.31	Dual, Bright finish stack only		$ 95.00	$ -
8.32	Single, Bright finish lower elbow & stack		$ 142.00	$ -
8.33	Dual, Bright finish lower elbow & stack		$ 283.00	$ -
8.34	Single, Bright finish heat shield only		$ 15.00	$ -
8.35	Dual, Bright finish heat shield only		$ 30.00	$ -
8.36	Bright finish stainless steel heat shield for frame mounted Mack Cap DPF		$ 164.00	$ -
8.37	50 Gallon LH steel 22" Dia fuel tank		STD	
8.38	66 Gallon LH steel 22" Dia fuel tank		$ 26.00	$ -
8.39	88 Gallon LH steel 22" Dia fuel tank		$ 299.00	$ -
8.40	116 Gallon LH steel 22" Dia fuel tank		$ 355.00	$ -
8.41	50 Gallon LH aluminum 22" Dia fuel tank		$ 65.00	$ -
8.42	66 Gallon LH aluminum 22" Dia fuel tank		$ 88.00	$ -
8.43	88 Gallon LH aluminum 22" Dia fuel tank		$ 363.00	$ -
8.44	116 Gallon LH aluminum 22" Dia fuel tank		$ 423.00	$ -
8.45	50 Gallon LH Steel D-Shape		$ 1.00	$ -
8.46	66 Gallon LH Steel D-Shape		$ 55.00	$ -
8.47	88 Gallon LH Steel D-Shape		$ 239.00	$ -
8.48	116 Gallon LH Steel D-Shape		$ 430.00	$ -
8.49	50 Gallon LH Aluminum D-Shape		$ 65.00	$ -

Spec #	Description	Qty	Price	Subtotal
8.50	66 Gallon LH Aluminum D-Shape		$ 109.00	$ -
8.51	88 Gallon LH Aluminum D-Shape		$ 308.00	$ -
8.52	116 Gallon LH Aluminum D-Shape		$ 494.00	$ -
8.53	66 Gallon LH Steel D-Shape with Integral DEF Tank		$ 85.00	$ -
8.54	88 Gallon LH Steel D-Shape with Integral DEF Tank		$ 346.00	$ -
8.55	111 Gallon LH Steel D-Shape with Integral DEF Tank		$ 454.00	$ -
8.56	66 Gallon LH Aluminum D-Shape with Integral DEF Tank		$ 141.00	$ -
8.57	72 Gallon LH Aluminum D-Shape 26" Dia. with Integral DEF Tank		$ 306.00	$ -
8.58	88 Gallon LH Aluminum D-Shape with Integral DEF Tank	1	$ 373.00	$ 373.00
8.59	93 Gallon LH Aluminum D-Shape 26" Dia. with Integral DEF Tank		$ 434.00	$ -
8.60	111 Gallon LH Aluminum D-Shape with Integral DEF Tank		$ 505.00	$ -
8.61	50 Gallon RH steel 22" Dia fuel tank		$ 484.00	$ -
8.62	66 Gallon RH steel 22" Dia fuel tank		$ 509.00	$ -
8.63	88 Gallon RH steel 22" Dia fuel tank		$ 783.00	$ -
8.64	116 Gallon RH steel 22" Dia fuel tank		$ 838.00	$ -
8.65	50 Gallon RH aluminum 22" Dia fuel tank		$ 548.00	$ -
8.66	66 Gallon RH aluminum 22" Dia fuel tank		$ 571.00	$ -
8.67	88 Gallon RH aluminum 22" Dia fuel tank		$ 845.00	$ -
8.68	116 Gallon RH aluminum 22" Dia fuel tank		$ 913.00	$ -
8.69	50 Gallon RH Steel D-Shape		$ 484.00	$ -
8.70	66 Gallon RH Steel D-Shape		$ 544.00	$ -
8.71	88 Gallon RH Steel D-Shape		$ 722.00	$ -
8.72	116 Gallon RH Steel D-Shape		$ 914.00	$ -
8.73	50 Gallon RH Aluminum D-Shape		$ 548.00	$ -
8.74	66 Gallon RH Aluminum D-Shape		$ 594.00	$ -
8.75	88 Gallon RH Aluminum D-Shape		$ 791.00	$ -
8.76	116 Gallon RH Aluminum D-Shape		$ 977.00	$ -
8.77	Single polished aluminum fuel tank		$ 189.00	$ -
8.78	Dual polished aluminum fuel tank		$ 378.00	$ -
8.79	Isolate RH fuel tank from fuel system for hyd oil		$ 29.00	$ -
8.80	Isolate LH fuel tank from fuel system for hyd oil		$ 29.00	$ -
8.81	Dual draw & return fuel system		$ 79.00	$ -
8.82	Filter neck screen for fuel tank		$ 68.00	$ -
8.83	Bright finish DEF tank cover - Requires with bright finish tanks		$ 28.00	$ -
8.84	Bright Finish Fuel Tank Straps - Single Tank	1	$ 31.00	$ 31.00
8.85	Bright Finish Fuel Tank Straps - Dual Tank		$ 61.00	$ -
8.86	Flocs oil change ststem w/disconnecting fittings		$ 110.00	$ -

9.0 ENGINE RELATED OPTIONS:

9.1	Delco 35 SI Brushless Alternator, 135 AMP		$ 98.00	$ -
9.2	Delco 24 SI Alternator, 130 AMP		STD	
9.3	Delco 24 SI Alternator, 145 AMP	1	$ 17.00	$ 17.00
9.4	Leece-Neville Alternator, 145 AMP		$ 68.00	$ -
9.5	Donaldson Single Stage Air cleaner per spec 12.1	1	$ 267.00	$ 267.00
9.6	Non-heated fuel/water separator, Racor 1000 FH	1	$ 336.00	$ 336.00
9.7	Coolant spin on filter/conditioner	1	$ 46.00	$ 46.00
9.8	Front engine powered take off adapter and radiator cut out	1	$ 99.00	$ 99.00
9.9	Air applied fan drive, _Horton DM Advantage 2 speed _____(Brand)		$ 74.00	$ -

Spec #	Description	Qty	Price	Subtotal
9.10	Radiator hose package (Silicone) per Spec 12.2 - N/A with Allison transmission		$ 158.00	$ -
9.11	Radiator hose package (Silicone) per Spec 12.2 - with Allison transmission	1	$ 231.00	$ 231.00
9.12	Silicone hoses, spring clamps on radiator & heater, 1/4 turn ball valve heater hose - N/A with BOC windshield washer		$ 204.00	$ -
9.13	Curved exhaust pipe end	1	STD	
9.14	Engine block heater		$ 63.00	$ -
9.15	In line fuel heater - Artic Fox in Line Fuel Heater		$ 391.00	$ -
9.16	Radiator bug screen	1	STD	
9.17	Engine brake system	1	$ 604.00	$ 604.00
9.18	Extended life anti-freeze	1	$ 19.00	$ 19.00
9.19	Starter motor options - Delco 39MT-MXT	1	STD	
9.20	Mitsubishi electric 105P planetary gear reduction		$ 45.00	$ -
9.21	Leece-Neville Alternator, 200 AMP		$ 500.00	$ -
9.22	Leece-Neville Alternator, 160 AMP Brushless		$ 102.00	$ -
9.23	Delco 36SI Alternator, 165A Amp Brushless		$ 171.00	$ -
9.24	Leece-Neville Alternator, 140 Amp		$ 48.00	$ -
9.25	Leece-Neville Alternator, 160 AMP Brush		$ 99.00	$ -
9.26	Meritor/Wabco 636 (37.4 CFM) air compressor		$ 753.00	$ -
9.27	Winterfront over radiator mtg bug screen		$ 120.00	$ -
9.28	Winter front cover only		$ 77.00	$ -
9.29	Corrosion resistant oil pan - Recommended for snow plow trucks		$ 121.00	$ -
9.30	Davco 382 heated fuel-water separator		$ 372.00	$ -
9.31	Racor fuel filter 1000 FH, 12V electrical heater with Mack integral fuel-water separator		$ 360.00	$ -
9.32	120V, 1500W block heater with 150W oil pan heater wired to same receptical		$ 132.00	$ -
9.33	Electric preheater		$ 51.00	$ -
9.34	Tether device -furnish cap retainer for oil fill, radiator overflow tank, battery box & tool box when furnish		$ 22.00	$ -
9.35	Rear engine PTO (Repto)		$ 1,748.00	$ -
9.36	Transmission rear mounted PTO		$ 337.00	$ -
9.37	Fuller transmission (lower left)		$ 27.00	$ -
9.38	Provision for local installation of rear mounted PTO (lower center) includes dash mounted indicator light		$ 153.00	$ -
9.39	Air operated PTO control - includes in cab control (RMPTO only)		$ 114.00	$ -
9.40	PTO switch and light with wiring and piping		$ 150.00	$ -

10.0 TRANSMISSION OPTIONS:
(After the first Six listed options, list manual and automatic transmission options. List make and model, # of speeds, type of shifting and whether or not transmission includes PTO gear(s) or not). Example:Allison 3000 HS, 5 speed, push button, no PTO.

10.1	2 plate 15½" ceramic clutch option for manual transmission		STD	
10.2	External grease fitting for throw out bearing		$ 7.00	$ -
10.3	Adjustment free option for 2 plate clutches		$ 120.00	$ -
10.4	Synthetic (TranSynd) lubrication for Automatic Transmission	1	$ 289.00	$ 289.00
10.5	Synthetic lubrication for manual transmission		STD	
10.6	Allison 3000-RDS 6 spd push button, PTO		$ 6,461.00	$ -

Spec #	Description	Qty	Price	Subtotal
10.7	Allison 4500-RDS 6 spd push button, PTO	1	$ 13,661.00	$ 13,661.00
10.8	Allison 4500-RDS-R 6 spd, with retarder, push button, PTO		$ 17,346.00	$ -
10.9	Allison 4000-RDS 5/6 spd, push button, PTO		$ 14,164.00	$ -
10.10	Mack TMD12O automated 12 spd transmission		$ 3,844.00	$ -
1011	Mack T309, 9 speed manual transmission, PTO		$ 560.00	$ -
10.12	Mack T309LR, 9 speed manual transmisssion, PTO		$ 711.00	$ -
10.13	Fuller RTX-14609B, 9 speed manual trans, PTO		$ 405.00	$ -
10.14	Mack T310, 10 speed manual transmission, PTO		STD	
10.15	Mack T310M, 10 speed manual transmission, PTO		$ 1,646.00	$ -
10.16	Mack T310ME, 10 speed manual trans, PTO		$ 1,821.00	$ -
10.17	Mack T310MLR, 10 speed manual trans, PTO		$ 1,882.00	$ -
10.18	Fuller FRO-14210C, 10 speed manual trans, PTO		$ 271.00	$ -
10.19	Fuller RTO-14908LL, 10 speed manual trans, PTO		$ 722.00	$ -
10.20	Fuller FRO-12210C, 10 speed manual trans, PTO		$ (252.00)	$ -
10.21	Fuller FRO-13210C, 10 speed manual trans, PTO		$ 35.00	$ -
10.22	Fuller FRO-15210C, 10 speed manual trans, PTO		$ 689.00	$ -
10.23	Fuller FRO-16210C, 10 speed manual trans, PTO		$ 1,141.00	$ -
10.24	Fuller RTO-16908LL, 10 speed manual trans, PTO		$ 1,427.00	$ -
10.25	Fuller FRO-18210C, 10 speed manual trans, PTO		$ 2,307.00	$ -
10.26	Fuller RTO-14908ALL, 11 spd manual trans, PTO		$ 1,178.00	$ -
10.27	Fuller RTO-16908ALL, 11 spd manual trans, PTO		$ 1,851.00	$ -
10.28	Mack T313LR, 13 speed manual transmission, PTO		$ 1,752.00	$ -
10.29	Mack T313, 13 speed manual transmission, PTO		$ 1,710.00	$ -
10.30	Fuller RTLO-14913A, 13 spd manual trans, PTO		$ 1,509.00	$ -
10.31	Fuller RTLO-16913A, 13 spd manual trans, PTO		$ 2,239.00	$ -
10.32	Fuller RTLO-18913A, 13 spd manual trans, PTO		$ 2,942.00	$ -
10.33	Fuller RTO-16915, 15 spd manual trans, PTO		$ 2,012.00	$ -
10.34	Mack T318LR, 18 speed manual transmission, PTO		$ 1,910.00	$ -
10.35	Mack T318, 18 speed manual transmission, PTO		$ 1,941.00	$ -
10.36	Fuller RTLO-16918B, 18 spd manual trans, PTO		$ 2,824.00	$ -
10.37	Fuller RTLO-18918B, 18 spd manual trans, PTO		$ 3,456.00	$ -
10.38	Air assist clutch		$ 192.00	$ -
10.39	Open grated clutch pedal		$ 4.00	$ -
10.40	Transmission oil cooler	1	$ 300.00	$ 300.00
10.41	Driveshaft guard for center bearing		$ 26.00	$ -
10.42	Transmission dust proofing		$ 14.00	$ -
10.43	T-Handle shift lever for Allison - Floor mounted		$ 196.00	$ -
10.44	Allison shift to neutral when park brake engaged	1	STD	
10.45	3rd or 4th gear hold for Allison transmission		$ 300.00	$ -
10.46	Stainless steel transmission coolant pipes	1	$ 175.00	$ 175.00
10.47	Allison fill tune and dip stick under hood		$ 133.00	$ -
10.48	GP1-23 Parker gear pump - requires M-Drive transmission and RMPO		$ 409.00	$ -
10.49	GP1-41 Parker gear pump - requires M-Drive transmission and RMPO		$ 417.00	$ -
10.50	GP1-60 Parker gear pump - requires M-Drive transmission and RMPO		$ 528.00	$ -
10.51	GP1-80 Parker gear pump - requires M-Drive transmission and RMPO		$ 566.00	$ -

Spec #	Description	Qty	Price	Subtotal
10.52	F1-61R Parker gear pump - requires M-Drive transmission and RMPO		$ 613.00	$ -
10.53	F1-81R Parker gear pump - requires M-Drive transmission and RMPO		$ 683.00	$ -
10.54	F1-101R Parker gear pump - requires M-Drive transmission and RMPO		$ 825.00	$ -
11.0	**ELECTRICAL OPTIONS:**			
11.1	Automatic reset circuit breakers - Some		$ 69.00	$ -
11.2	Battery disconnect off negative side in cab control		$ 93.00	$ -
11.3	Remote jump start terminals		$ 107.00	$ -
11.4	OEM daytime running lights	1	$ 23.00	$ 23.00
11.5	3000 CCA batteries in lieu of 1950CCA		$ 64.00	$ -
11.6	3 each 650/1950 CCA batteries in lieu of 2 each batteries	1	STD	
11.7	Switch for snowplow lights mounted on instrumental panel. Includes wiring terminated near headlights, for customer mounted auxiliary snowplow lights.	1	$ 75.00	$ 75.00
11.8	Vehicle speed sensor with speed signal at fuse panel for sander ground speed control system.	1	$ 10.00	$ 10.00
11.9	Dash mounted indicator body/hoist up body builder lamp		$ 64.00	$ -
11.10	RH/LH led work light on both side of truck		$ 109.00	$ -
11.11	Polished aluminum battery box cover		$ 50.00	$ -
11.12	Molded plastic with splash guard		$ 28.00	$ -
11.13	Battery shock pad		$ 4.00	$ -
11.14	Body Link w/cab floor pass thru hole/rubber boot		$ 1.00	$ -
11.15	Body Link w/o cab floor pass thru hole/rubber boot	1	STD	
11.16	2 Extra dash mounted illuminated toggle switches		$ 15.00	$ -
11.17	One extra dash mounted rocker switch thru battery for local installed		$ 10.00	$ -
11.18	One extra dash mounted rocker switch thru ignition for local installed		$ 19.00	$ -
11.19	Six extra switches 2-15A ignition, 1-20A ignition, 1-10A ignition, 1-5A battery, & 1-20A battery	1	$ 102.00	$ 102.00
11.20	Eight switches - front strobe, rear strobes, wing light, wing strobe, sander light, tail gate lock, and vibrator		$ 278.00	$ -
11.21	Back up alarm with intermittent feature (Ambient noise sensitive)		$ 84.00	$ -
11.22	Ecco back-up alarm 575 constant sound level	1	$ 72.00	$ 72.00
11.23	Ecco back-up alarm SA917 ambient noise sensitive		$ 94.00	$ -
11.24	Pollak 41-722 constant audible (mounted on rear crossmenber)		$ 77.00	$ -
11.25	Fog lights		$ 89.00	$ -
11.26	Fog lights provisions - includes dash control & wiring for local installation of fog lights		$ 12.00	$ -
11.27	Rear brake lights circuit activated when spring brakes are applied and key in run position - no tail lights		$ 50.00	$ -
11.28	Omit rear tail lights		$ (40.00)	$ -
11.29	Incandescent tail light module		$ 88.00	$ -
11.30	LED type tail lights	1	$ 191.00	$ 191.00
11.31	Trailer hook-up light		$ 35.00	$ -
11.32	Three Mack 800 CCA AGM Long Life Batteries		$ 253.00	$ -
11.33	Chassis & power harness with heavy duty casing		$ 148.00	$ -
11.34	Dash mounted switch for strobe light		$ 30.00	$ -
12.0	**CAB EXTERIOR OPTIONS:**			
12.1	Dual electric horns		$ 4.00	$ -

Spec #	Description	Qty	Price	Subtotal
12.2	Air horns, dual, round, with snow shields		$ 91.00	$ -
12.3	Dual rectangular air horns	1	$ 69.00	$ 69.00
12.4	Fender mirrors per Spec 12.4	1	$ 178.00	$ 178.00
12.5	Heated mirrors per Spec 12.5 - _____Bulldog _____West Coast _____Areo		$ 105.00	$ -
12.6	Remote control for R.H. mirror & heated - __X____Bulldog _____West Coast _____Areo	1	$ 364.00	$ 364.00
12.7	Remote control for dual mirrors & heated - _____Bulldog _____West Coast _____Areo		$ 456.00	$ -
12.8	Dupont Highway orange paint or equal		$ 34.00	$ -
12.9	Premium paint color option		$ 145.00	$ -
12.10	Imron paint option		STD	
12.11	Imron and clear coat paint option	1	$ 137.00	$ 137.00
12.12	Top of hood painted flat black		$ 584.00	$ -
12.13	Cab Air Ride Suspension	1	STD	
12.14	Tilting hood per Spec 12.8	1	STD	
12.15	Butterfly option on hood		$ 432.00	$ -
12.16	Cab visor, external, painted to match cab color	1	$ 139.00	$ 139.00
12.17	Front fender extensions	1	$ 101.00	$ 101.00
12.18	Front fender mud flaps	1	STD	
12.19	Arctic winter wiper blades		$ 18.00	$ -
12.20	Optional windshield washer tank		$ 25.00	$ -
12.21	Per truck charge for all trucks, key identical		$ 19.00	$ -
12.22	RH observation prism window in door		$ 69.00	$ -
12.23	Front tow hooks	1	STD	
12.24	Rear tow hooks		$ 21.00	$ -
12.25	Heated electric wiper blades		$ 114.00	$ -
12.26	Heated windshield	1	$ 425.00	$ 425.00
12.27	One piece windshield	1	$ 80.00	$ 80.00
12.28	Tinted windshield and sides w/50% transmittance gray, tinted rear		$ 17.00	$ -
12.29	Bright finish hood intake	1	$ 15.00	$ 15.00
12.30	Bright finish bars with surround grille		$ 148.00	$ -
12.31	Bright finish bars with surround grille with front frame extension	1	$ 231.00	$ 231.00
12.32	Bright finish grille		$ 31.00	$ -
12.33	Bullet type chrome marker & clearance lights		$ 73.00	$ -
12.34	Led type marker & clearance lights	1	$ 73.00	$ 73.00
12.35	RH tool box mounted on frame rail		$ 213.00	$ -
12.36	Bug deflector mounted on hood - N/A with butterfly hood		$ 72.00	$ -
12.37	Heated convex mirrors		$ 32.00	$ -
12.38	Electronic keyless entry		$ 125.00	$ -
12.39	Bright finish RH fender mirror		$ 65.00	$ -
12.40	Stainless steel exterior sun visor		$ 238.00	$ -
12.41	Bright Finsh hood latches		$ 86.00	$ -
12.42	10" round bright finish heated fender mirrors		$ 225.00	$ -
12.43	Rect convex mirror above RH driver door window		$ 22.00	$ -
12.44	Hadley/Kam 4-way mirrors with chrome steel - RH/LH both motorized & heated		$ 242.00	$ -

13.0 CAB INTERIOR OPTIONS:

Spec #	Description	Qty	Price	Subtotal
13.1	**Medium grade interior trim package**			$ -
13.1A	Sandstone Color with woodgrain instrument panel		$ 330.00	$ -
13.1 B	Sandstone Color with brushed metalic instrument panel		$ 330.00	$ -
13.1C	Slate Gray Color with woodgrain instrument panel		$ 330.00	$ -
13.1D	Slate Gray Color with brushed metalic instrument panel		$ 330.00	$ -
13.2	**Premium grade interior trim package**			$ -
13.2A	Sandstone Color with woodgrain instrument panel		$ 1,094.00	$ -
13.2B	Sandstone Color with brushed metalic instrument panel		$ 1,094.00	$ -
13.2C	Slate Gray Color with woodgrain instrument panel		$ 1,094.00	$ -
13.2D	Slate Gray Color with brushed metalic instrument panel	1	$ 1,094.00	$ 1,094.00
13.3	Round universal gauge package	1	STD	
13.4	Power window, passenger side		$ 202.00	$ -
13.5	Power window/both driver and passenger window		$ 312.00	$ -
13.6	AM/FM premium stereo CD w/weatherband, MP3, hand free interface bluetooth	1	STD	
13.7	O.E.M factory installed, air conditioning	1	STD	
13.8	Dash mounted air cleaner air restriction gauge	1	STD	
13.9	AM/FM premium stereo CD w/weatherband, MP3, hand free interface bluetooth, XM Satellite		$ 151.00	$ -
13.10	AM/FM premium stereo CD w/weatherband, MP3, hand free interface bluetooth, Sirus Satellite		$ 151.00	$ -
13.11	Transmission temp gauges	1	STD	
13.12	Windshield defroster fan w/switch dash mounted		$ 84.00	$ -
13.13	Transmission oil sensor (check & fill) Allison only	1	STD	
13.14	CB hot jacks dash mounted		$ 12.00	$ -
13.15	Tilt & telescope steering wheel	1	STD	
13.16	Self canceling turn signals	1	$ 26.00	$ 26.00
13.17	Bostrom Talladega 915 Hi-Back air driver seat		$ 25.00	$ -
13.18	Bostrom Talladega 915 wide ride Hi-Back air driver		$ 175.00	$ -
13.19	Air-Sears Atlas 70 hi-back with black fabriform cushions		$ 360.00	$ -
13.20	National 2000 hi-back air driver seat - single chamber air lumbar, 2	1	$ 100.00	$ 100.00
13.21	National 2000 hi-back air driver seat - three chamber air lumbar, 2 position front cushion adjustable front cushion with adjustable rear cushion		$ 191.00	$ -
13.22	Mack fixed rider seat mid-back with integral storage compartment	1	$ 79.00	$ 79.00
13.23	Mack fixed rider seat hi-back with integral storage compartment		$ 102.00	$ -
13.24	Extended non suspension rider seat		$ 97.00	$ -
13.25	Mack fixed hi-back rider seat		$ 43.00	$ -
13.26	Bostrom Talladega 900R mid-back non suspension rider seat		$ 52.00	$ -
13.27	Bostrom Talladega 915 mid back air rider seat		$ 192.00	$ -
13.28	Bostrom Talladega 915 hi-back air rider seat		$ 238.00	$ -
13.29	National 2000 mid-back air rider seat		$ 206.00	$ -
13.30	National 2000 hi-back air rider seat		$ 240.00	$ -
13.31	Omit rider seat		$ (50.00)	$ -
13.32	Inboard mounted driver arm rest	1	STD	
13.33	Inboard mounted rider arm rest - Air Ride Seat Only		STD	
13.34	Cloth with vinyl driver & rider seat	1	STD	
13.35	Driver seat dust cover	1	STD	
13.36	Passenger seat dust cover - Not Available with fix passenger seat		STD	

Spec #	Description	Qty	Price	Subtotal
13.37	All ultral leather drive and ride set		$ 92.00	$ -
13.38	Orange driver & rider seat belt		$ 13.00	$ -
13.39	Roof vent ventilation		$ 154.00	$ -
13.40	Push button type starter		$ 13.00	$ -
13.41	Diagonal grab handle on inside of driver door		$ 29.00	$ -
13.42	Co-pilot driver display (enhanced 4.5" diagonal graphic LCD display w/4-button stalk control - includes guardog routine maintenance monitoring	1	STD	
13.43	Roadwatch ambieit air temp gauge for outside and road temps - requires areo-dynamic mirrors		$ 624.00	$ -
13.44	Roadwatch ambieit air temp gauge for outside and road temps without display - includes cable to D panel with 6" extra wire		$ 930.00	$ -
13.45	Roadwatch ambieit air temp gauge for outside and road temps with display on dash panel		$ 1,040.00	$ -
13.46	5lb fire extinguisher between LH seat base and door with valve aimed rearward		$ 64.00	$ -
13.47	Reflector kit parallel to inside of rider base seat		$ 22.00	$ -
13.48	Air conditioning blend air HVAC w/pads		$ 127.00	$ -
13.49	Cab cleanout - includes in cab pneumatic line		$ 44.00	$ -
13.50	In dash large storage pocket - not available with dash mounted shfter for Allison		$ 37.00	$ -
13.51	40 Channel CB Radio		$ 197.00	$ -
13.52	48" Radio antenna right side mirror mounted		$ 4.00	$ -
13.53	48"CB Antenna left side mirror mounted		$ 37.00	$ -
13.54	CB mounting in console & external speakers		$ 103.00	$ -
13.55	Auto shutoff for radio when truck is in reverse		$ 46.00	$ -
13.56	Exhaust pyrometer & transmission oil temperature gauges	1	STD	
13.57	Exhaust pyrometer, transmission oil temperature, manifold pressure and air application gauges		$ 73.00	$ -
13.58	Exhaust pyrometer, transmission oil temperature, manifold pressure and air application gauges, Air Suspension		$ 96.00	$ -
13.59	Rear Axle temperature gauge		$ 88.00	$ -
13.60	Light & buzzer for seat belt		$ 33.00	$ -
13.61	Red floor lighting w/switch plus (4) door lamps w/switches		$ 99.00	$ -
13.62	Interior storage console mounted on floor between seats w/12 volt power outlet		$ 297.00	$ -
13.63	Bodybuilder interior console mounted to floor between seats		$ 201.00	$ -

14.0 MN/DOT OPTIONS:

14.1	Additional warranty coverage per spec 12.9			$ -
14.1A	Engine Plan 1 60 months 250,000 miles		$ 1,200.00	$ -
14.1B	Engine Plan 1 72 months 250,000 miles		$ 2,200.00	$ -
14.1C	Engine Plan 1 84 months 250,000 miles		$ 2,520.00	$ -
14.1D	Engine Plan 1 60 months 250,000 miles - HP over 460 horses		$ 2,000.00	$ -
14.1E	Engine Plan 1 72 months 250,000 miles - HP over 460 horses		$ 3,300.00	$ -
14.1F	Engine Plan 1 84 months 250,000 miles - HP over 460 horses		$ 3,800.00	$ -
14.1G	Engine Plan 2 60 months 250,000 miles	1	$ 1,900.00	$ 1,900.00

Spec #	Description	Qty	Price	Subtotal
14.1H	Engine Plan 2 72 months 250,000 miles		$ 3,800.00	$ -
14.1I	Engine Plan 2 84 months 250,000 miles		$ 4,300.00	$ -
14.1J	Engine Plan 2 60 months 250,000 miles - HP over 460 horses		$ 2,950.00	$ -
14.1K	Engine Plan 2 72 months 250,000 miles - HP over 460 horses		$ 5,675.00	$ -
14.1L	Engine Plan 2 84 months 250,000 miles - HP over 460 horses		$ 6,450.00	$ -
14.1M	Engine after-treatment systems (EATS) 60 months 250,000 miles	1	$ 675.00	$ 675.00
	For Prebuild and Pilot meets See RFB special Terms and conditions			
14.2	Paul/Minneapolis area.		$ 1.00	$ -
14.3	Pilot inspection meeting (per person).		$ 900.00	$ -
15.0	**TRAILER TOW OPTIONS:**			
15.1	Trailer tow package extended to rear of frame	1	$ 347.00	$ 347.00
15.2	Trailer package extend to rear of frame per Spec 12.12		$ 335.00	$ -
15.3	Single 7 pins Std SAE type, end of frame	1	$ 115.00	$ 115.00
16.0	**MANUALS / INTEREST FEE:**			
16.1	Percent interest per month (non-compounding) on unpaid cab & chassis balance. Applies only to CPV Members. (Payable after trade-in is delivered to vendor). Percentage/per month.		$ 1.50	$ -
	SEE Special Terms and Conditions re interest to State agencies.			
16.2	Manuals in print form, parts repair and service, per set		$ 900.00	$ -
16.3	Manuals in CD form, parts repair and service, per set		$ 500.00	$ -
16.4	Premium Tech Tool		$ 3,000.00	$ -
17.0	**Delivery Charges:**			
	Price per loaded mile Starting Point			
17.1	Roseville, MN 55311		$ 2.00	$ -
18.0	**Maintence/ Body Shop Labor rates**			
18.1	Rate for Initial Inspection/Diagnostoce		$ 130.00	$ -
18.2	Rate for Mechanical Work		$ 130.00	$ -
18.3	Rate for Body Work		$ 130.00	$ -
19.0	**Quantity Discounts:**			
	corresponding discount offered to the purchaser. More than one			
19.1				$ -
19.2				$ -
20.0	**Next Model Year Upcharges**			
	Enter the following Production Model Year here >>>>>>>>>		2017	
20.1	Percentage Upcharge for the following Model Year Base Unit	1	$ 1,500	$ 1,500.00
20.2	Percentage Upcharge for the following Model Year Options		$ 0	$ -

Total Cost: $ 116,579.00

NUSS TRUCK & EQUIPMENT
www.nussgrp.com

☐ 6500 US HWY 63 S, PO BOX 6699
ROCHESTER, MN 55903
507-288-9488 507-424-4156 (FAX)

☒ 2195 W CTY RD C2, PO BOX 130820
ROSEVILLE, MN 55113
651-633-4810 651-635-0928 (FAX)

☐ 2625 QUAIL RD NE
SAUK RAPIDS, MN 56379
320-253-6941 320-253-0176 (FAX)

☐ 53976 208TH LN, PO BOX 969
MANKATO, MN 56002
507-345-6225 507-387-5886 (FAX)

☐ 3028 TRUCK CENTER DR
DULUTH, MN 55806
218-628-0333 218-628-1822 (FAX)

☐ 12540 DUPONT AVE S
BURNSVILLE, MN 55337
952-894-9595 952-894-1619 (FAX)

VEHICLE PURCHASE AGREEMENT

DATE: 01/12/2016

SALESPERSON: PROW

☒ NEW ☐ USED ☐ TRAILER ☐ ORDER OUT ☐ IN STOCK

PURCHASER: McLeod County

CONTACT/TITLE:

ADDRESS: 1400 Adams Street SE

E-MAIL ADDRESS:

CITY STATE: Hutchinson

COUNTY: McLeod

ZIP CODE: 55350

PHONE NUMBER: 320-484-4363

FAX NUMBER:

The Undersigned Purchaser hereby agrees to purchase from NUSS TRUCK GROUP INC. or SUBSIDIARY, hereinafter referred to as the Dealer, 1 new or used vehicle(s) together with the equipment below set forth (which vehicle(s) and equipment are called "said vehicle(s)") to be delivered on or about _____ according to the following specifications, terms, and conditions:

STOCK NO.	YEAR	MAKE	MODEL	MILEAGE	VIN
	2017	MACK	GU713		PENDING

WARRANTIES and/or **REPRESENTATIONS**

☒ Manufacturer's Warranty Applies

☐ **AS-IS: NO DEALER WARRANTY. DEALER DISCLAIMS ANY & ALL EXPRESS OR IMPLIED WARRANTIES.**

☐ Other: _____

PURCHASER INITIAL HERE: _____

GVWR/GCWR: The Gross Vehicle Weight (GVWR), or Gross Combination Weight Rating (GCWR), of the vehicle subject to this order is _____ lbs. Seller disclaims any and all liability for damages resulting from operation of the vehicle in excess of the above stated GVWR or GCWR.

PURCHASER INITIAL HERE: _____

TYPE OF TRANSACTION

☐ Financed. Finance Company: _____

☒ Cash (including customer based financing).

Lien Holder: _____

Phone #: _____

DRIVER/INSURANCE INFORMATION (for 2000 form)

Insurance Agent: _____

Insurance Company: _____

Policy #: _____

Driver's License #: _____ Date of Birth: _____

BASE PRICE OF VEHICLE SOLD	$116,579.00
1. Total of Options/Accessories (carried over from Addendum)	$0.00
2. Dealer Retail Price	$116,579.00
3. Discount	$0.00
4. Total Cash Price (2 less 3)	$116,579.00
5. Trade-in Allowance	$0.00
6. Trade Difference (4 less 5)	$116,579.00
7. MN Sales Tax on Trade Difference 6.50%	$7,577.64
8. Federal Excise Tax	$0.00
9. License / Registration Fees	$75.00
10. City/County Excise Tax	$0.00
11. Document Fee	$0.00
12. Warranty	$0.00
13. Balance Due to _____ on trade-in	$0.00
14. Sub Total (Sum 6 through 13)	$124,231.64
15. Less Cash Down Payment on Order	$0.00
16. Sub Total (14 less 15)	$124,231.64
17. Less Additional Cash Due _____	$0.00
DUE ON DELIVERY	$124,231.64

DELIVERY INFORMATION

DELIVER TO: TOWMASTER, LITCHFIELD, MN

ADDITIONAL ITEMS OR CONDITIONS OF SALE:

PO # 20120308-01

EQUIPMENT TO BE TRADED

STOCK NO.	YEAR	MAKE	MODEL	MILEAGE	VIN
STOCK NO.	YEAR	MAKE	MODEL	MILEAGE	VIN

IT IS FURTHER UNDERSTOOD AND AGREED

This Purchase Contract is subject to the following terms and conditions which have been mutually agreed upon:

1. That the Purchaser, before or at the time of taking delivery of the motor vehicle covered by the Purchase contract, will execute such other forms of agreements or documents as may reasonably be required by the dealer.
2. If the Manufacturer makes any changes in the model or design of any accessories and/or parts of any new motor vehicles at any time, it does not create any obligation on the part of the Dealer to make corresponding changes in the vehicle covered by this order either before or subsequent to the delivery of such vehicle to the Purchaser.
3. The Dealer shall have the right to re-appraise the motor vehicle to be traded-in or modify accordingly the delivery price of the motor vehicle purchased herein, if the said trade-in vehicle is subsequently damaged or parts and/or accessories have been removed or replaced, or if it exceeds any mileage/kilometer limitation stated on the face of this contract.

PURCHASER INITIAL HERE: _____

TERMS AND CONDITIONS

This purchase agreement is tendered by the Purchaser for acceptance by the Dealer, and it will not be binding upon the Dealer unless accepted and signed by the Dealer.

If the terms of payment herein provided are other than cash, the Purchaser agrees to execute and deliver to the Dealer, prior to the delivery of said vehicle(s), a security agreement, in the form customarily required by it, covering said vehicle(s) in order to secure the payment of the indebtedness due hereunder. The Purchaser further agrees that this purchase agreement shall be subject to all the terms and conditions of said security agreement, which shall supersede this purchase agreement to the extent inconsistent herewith; provided that Purchaser's warranty as to any used motor vehicle or equipment traded in by the Purchaser and taken by the Dealer as part payment hereunder (hereinafter such used motor vehicle or equipment is called the "used equipment") shall survive the execution of the security agreement.

The Purchaser warrants that the used equipment, if any, is free and clear of all liens and/or encumbrances of any nature whatsoever, and that the Purchaser has good and marketable title to the used equipment at the time of delivery thereof to the Dealer, unless noted otherwise under other conditions of sale. The used equipment is to be delivered to the Dealer in the same condition and appearance in which it was when first inspected by the Dealer or its agent. The Dealer, upon delivery of the used equipment, shall have the right once again to inspect the used equipment, and the Dealer shall be the sole judge as to its condition, with the right to accept or reject the used equipment at its option. If the used equipment is not in a condition and appearance as good as it was when first inspected by the Dealer, the Dealer shall have the right to revalue the amount of allowance offered for such equipment and the total cash purchase price shall be increased accordingly. The Purchaser agrees that the amount of the allowance made upon the used equipment, if any, is to be applied by the Dealer as part payment on the purchase price of said vehicle(s).

The Dealer shall not be held responsible for any loss, damage, detention, delay or failure to deliver resulting from any cause which is unavoidable or beyond its reasonable control, including, but not limited to, fire, flood, natural disaster, strike or labor disturbance, accident, vandalism, riot or insurrection, war, any order, decree. law or regulation of any court, government or governmental agency, shortage of materials, demand in excess of available supply, failure or interruption of normal transportation or power facilities; AND IN NO EVENT SHALL THE DEALER BE LIABLE FOR CONSEQUENTIAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOSS OF INCOME. The receipt of said vehicle(s) by the Purchaser upon delivery shall constitute a waiver of all claims for loss or damage due to delay.

In the event that the within purchase agreement is accepted by the Dealer and the Purchaser fails to accept delivery and perform this contract pursuant to its terms, the Dealer shall have the right to retain the amount paid to the Dealer in cash and/or the used equipment on account of the purchase price of said vehicle(s) as liquidated damages in addition to such other rights as the Dealer may have under law. In the event that the within purchase agreement is canceled by mutual written agreement of the Dealer and the Purchaser or if the Dealer is unable to make delivery of said vehicle(s), the Dealer will return and the Purchaser will accept the cash and the used equipment (or if the used equipment shall have been sold, the net amount received by the Dealer from the sale thereof) in full discharge of any obligations of the Dealer to the Purchaser hereunder.

A security interest in said vehicle(s) shall remain in the Dealer until the payment in full of the purchase price or, if the terms of payment herein provided are other than cash, until the execution and delivery of a security agreement, as hereinabove provided, at which time the terms of said security agreement shall control.

In the event of Purchaser's failure to make payment of the purchase price when due, the Dealer may take immediate possession of said vehicle(s), without demand or further notice. For this purpose and in furtherance thereof, the Purchaser shall, if the Dealer so requests, make said vehicle(s) available to the Dealer at a reasonably convenient place designated by it, and the Dealer shall have the right, and the Purchaser does hereby authorize and empower the Dealer, its agents, servants or employees, to enter upon the premises wherever said vehicle(s) may be and remove the same; and the Purchaser hereby expressly waives any action or right of action of any kind whatsoever against the Dealer, its agents, servants or employees because of the removal, repossession or retention of said vehicle(s) or otherwise.

The Purchaser agrees that if the cost of labor, materials, body, accessories or other equipment or component parts increases beyond the basis upon which the price set forth herein was established, then the Dealer, at any time before delivery, may give the Purchaser written notice of an increase in price, and such increased price shall be the contract price, unless Purchaser within ten days thereafter shall give Dealer written notice of cancellation. Any such increase in the contract price, pursuant to this provision, however, shall not prevent additional increases, if necessary, under the circumstances set forth herein at any time prior to delivery.

If the cost to the Dealer of insurance to be furnished by the Dealer hereunder is increased at any time prior to the delivery of said vehicle(s) the Purchaser agrees to pay for the insurance herein provided for at such increased rate.

ALL TAXES NOW OR HEREAFTER IMPOSED UPON THE SALE OF SAID VEHICLE(S) SHALL BE PAID BY THE PURCHASER.

The Purchaser agrees that all previous communications between the Purchaser and the Dealer, either verbal or written, with reference to the subject matter of this purchase agreement, are hereby abrogated. The Purchaser further agrees that no modification of this Agreement shall be binding upon the Dealer unless such modifications shall be in writing and agreed to and accepted in writing by authorized personnel of the Dealer.

This instrument contains the entire agreement between the parties, and there are no understandings or representations not contained herein.

THE DEALER AND THE MANUFACTURER MAKE NO WARRANTIES AS TO SAID VEHICLE(S), EXPRESS, IMPLIED, OR IMPLIED BY LAW, EXCEPT THE MANUFACTURER'S STANDARD VEHICLE WARRANTY, A COPY OF WHICH HAS BEEN DELIVERED TO THE PURCHASER AND WHICH IS INCORPORATED HEREIN BY REFERENCE. THE DEALER AND THE MANUFACTURER SPECIFICALLY DISCLAIM ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE AND ANY LIABILITY FOR CONSEQUENTIAL DAMAGES.

THIS MAY BE A BINDING CONTRACT AND YOU MAY LOSE ANY DEPOSITS IF YOU DO NOT PERFORM ACCORDING TO ITS TERMS.

UNLESS OTHERWISE STATED, ALL INCENTIVES TO THE DEALER.

THE TERMS AND CONDITIONS HEREOF ARE A PART OF THIS AGREEMENT. THE PURCHASER ACKNOWLEDGES HAVING READ THIS AGREEMENT INCLUDING SUCH TERMS AND CONDITIONS AND FURTHER, PURCHASER ACKNOWLEDGES RECEIVING A COPY OF THIS AGREEMENT.

Buyer Signature _____ Buyer Name/Title _____

DATE

Dealer Accepted X _____

DATE

THIS ORDER IS NOT VALID UNLESS ACCEPTED AND SIGNED BY A SALES MANAGER OR OFFICER OF THE COMPANY.

Towmaster, Inc.

61381 US Hwy. 12, Litchfield, MN
Phone: 800-462-4517 / 320-693-7900

Truck Equipment - Cutting Edges - Asphalt Repair Equipment

FX: 320-693-7921

Sales Order

Parts FX: 320-593-5703

Bill To: **Cust#:** **2947** **Phone:**
MCLEOD COUNTY HWY DEPT
1400 ADAMS STREET S.E.
HUTCHINSON, MN 55350
320-234-0234
FAX:
320-234-6971

Ship To: **Phone:**
MCLEOD COUNTY HWY DEPT
1400 ADAMS STREET S.E.
HUTCHINSON, MN 55350
320-234-0234
FAX:
320-234-6971

Contact:

Contact: Brian Schrupp 320-234-4454

PO#	QUOTE No.	Terms	Created Date	Latest Rev Date	Appx. Ship Date
	13497-TGG	NET 30 DAYS	12/04/2015	12/4/2015	1/3/2016

Trk VIN		MO #		CO #	194151	Salesman	Tom Gertgen

Freight Instructions: **Build Instructions:** **Other Credit:** **Other Charge:**

ATTENTION: **BRIAN SCHRUPP** **100790**

Qty	Part No.	Description	Discount Rate: 0.00%	Price Each	Net Amt
1	9900068	Body 14'6" EDGE-RC/CS-56-46-46 - - 56" 3/16" Hardox 450 Front w/CS hoist doghouse, 46" 3/16" Hardox 450 radius sides (no pockets), 46" 3/16" Hardox 450 Tailgate, 1/4" Hardox-450 Floor, 8" I-Beam Longsills, Air-trip ready linkage, unpainted.		10,627.00	10,627.00
1	9901704	Painting of Dump Body; includes media blasting of entire exterior & understructure, Urethane Primed, & Urethane Top Coats applied. Understructure is seam sealed, and painted Gloss Black. Finish coated with "RED" Polyurethane Enamel to Match (paint code) cab		2,650.00	2,650.00
1	9901701	Installation of Dump Body to hoist		1,750.00	1,750.00
1	9900145	Body acc'y TMTE Air trip kit, w/solenoid valve,		259.00	259.00
1	9901702	Installation of air operated tailgate latch kit		268.00	268.00
1	9900147	Body acc Box Vibrator - Cougar model DC3200		674.00	674.00
1	9901703	Installation of Box Vibrator		302.00	302.00
1	9900155	Cabshield, 1/2 type Stationary Free-Standing style, w/painted CARBON STEEL canopy, Hot-Dipped Galvanized tubing construction support stand, (2) shovel holders, & reservior mounts, Installed.		1,748.00	1,748.00
1	9900179	Walkrail (3-1/2" open-grip) dual 14' RC & RCL body, Attached		1,033.00	1,033.00
1	9900206	Ladder Flip-A-Way Access ladder Pkg (Carbon Steel) ea, Installed		343.00	343.00
1	9900211	Body acc'y Dual "split" sander manifolds in rear corner posts		311.00	311.00
1	9904246	Light Warning TMTE1SS-3 PKG: (2) STAINLESS STEEL 23H 3-light LED Micro-Edge, (2) 5M-400 Super-LED, (2) Side TIR3 LED, (2) 400 Max B-T-T LED, & (2) 400 LED BU Lights, in Stainless M Housings, (1) TIR3 LED Wing light, and (2) 4" LED work lights Installed		4,149.00	4,149.00
1	9900244	Light Mirror mt HOH plow light pkg INSTALLED		667.00	667.00
1	9900272	Fender set Pro-Tech Bright Alum diamond plate Tandem Axle, full radius, installed		1,410.00	1,410.00

Towmaster, Inc.
61381 US Hwy. 12, Litchfield, MN
Phone: 800-462-4517 / 320-693-7900

Truck Equipment - Cutting Edges - Asphalt Repair Equipment

1	9904080	Removeable Fender Mounts	512.00	512.00
1	9900276	Tarp Pulltarp (SGL or TDM) model S-9 Supershield tarp system w/A2F tarp, sideflaps & tiedowns, w/quick removable mounts, installed	1,796.00	1,796.00
1	9901691	RoadWatch RWSS Sensor only INSTALLED	467.00	467.00
1	9902930	RoadWatch Force America Interface CABLE ONLY for 6100, installed	199.00	199.00
1	9900317	Hoist Towmaster/MAILHOT CS130-5.5-3 DOUBLE ACTING	2,913.00	2,913.00
1	9901711	Installation of Telescopic DOUBLE acting hoist	1,287.00	1,287.00
1	9900311	Hoist TMTE 48" Stabilizer	1,353.00	1,353.00
1	9902503	Installation of TMTE Stabilizer & Safety Props	387.00	387.00
1	9902924	Scraper FALLS IB-10A 1" MB, w/single lift cylinder W/12" bolt-on extension (11' total), LESS CUTTING EDGES	6,193.00	6,193.00
1	9901705	Installation of underbody fixed angle scraper w/single lift cylinder	2,010.00	2,010.00
1	9904232	Up Charge Electric pressure transmitter to read on LCD screen installed	427.00	427.00
1	9900351	Scraper FORCE reverse/Auto-Lift system, ADD-A-FOLD valve, installed	466.00	466.00
1	9902946	Wing Falls RHSDL10A-STDPB Primed LESS CUTTING EDGES	7,314.00	7,314.00
1	9900388	Installation Falls SDL Series Wing - w/Bulkhead Couplers MUST WORK WITH PUP HOOKED UP	3,804.00	3,804.00
1	9901431	Wing Falls RL (REAR LIFT) up charge SDL WING	391.00	391.00
1	9900480	Wing Falls Red - Paint Moldboard	278.00	278.00
1	9900567	Plow Hitch Falls 46XB2/STD/STD/SA/SPR-RET/HITCH	2,743.00	2,743.00
1	9900546	Plow Hitch Falls V-Plow Ears added	132.00	132.00
1	9900589	Installation Falls Plow Hitch - 40 Series 3Line/STDBLKHD	1,595.00	1,595.00
1	9900619	Plow Push Unit Falls 20/26/40/46 Series Std	746.00	746.00
1	9902506	Plow Falls Reversible snow wheels (Renville Co Style)	3,366.00	3,366.00
1	9900639	Plow Falls Rubber Belt Deflector Kit - Installed	306.00	306.00
1	9900641	Plow Falls Parking Stand - Screw Adj Style	273.00	273.00
1	9903094	Plow Falls RH312R/HYD-TLT/NOSHU/PRI-E1/7GA LESS CUTTING EDGES	7,009.00	7,009.00
1	9900682	Plow Falls Red Paint, Rev Plow, w/installation	369.00	369.00
1	9900758	Hitch TMTE Heavy Duty plate ass'y w/light holes in plate,	317.00	317.00
1	9901716	Hitch Installation of Pup Hitch (weld in style)	687.00	687.00
1	9900764	Hitch PREMIER 2300 Air Cushion Pintle, installed	702.00	702.00
1	9900769	Hitch TMTE Pup hyd line w/std Coupler & pup trip switch pkg, installed	591.00	591.00

Towmaster, Inc.
61381 US Hwy. 12, Litchfield, MN
Phone: 800-462-4517 / 320-693-7900

Truck Equipment - Cutting Edges - Asphalt Repair Equipment

1	9900805	Sander Falls 1ASD9SS-4P-1D-1S, 9" x 4" Auger, Stainless Steel Unit, LH (or RH) Discharge, Berm Chute, Single Poly Spinner Ass'y, Complete	4,536.00	4,536.00
1	9901718	Sander Install & dual manifold RH & LH rear	614.00	614.00
1	9900823	Sander TMTE Exterior (removable) sander/tailgate spill plates, Stainless Steel	356.00	356.00
1	9900851	Valve System, Force Add-A-Fold MCV-ISO Valve 9 Functions , INSTALLED hoist, pup, plow, plow steer, wing toe,wing heel,scraper,plow tilt, sander auger, sander spinner pup section on seperate line RUN HOSES AND INSTALL FITTINGS TO RUN FRONT BROOM ONLY	9,960.00	9,960.00
1	9902501	Control System Force ULTRA-5-6100 Commander control, Installed	13,253.00	13,253.00
1	9900874	Filter Force IN-TANK mounted filter installed	446.00	446.00
1	9900882	Reservoir TMTE Cabshield mt (stainless steel) w/intank filter provision, installed	2,182.00	2,182.00
1	9900888	Pump Force FASD45L LS (6 ci) installed	3,523.00	3,523.00
1	9900998	Valve Force PUP HOIST Section ADD-A-FOLD, Includes extra section & harness provision pup line will have an electric dump valve to relieve the hose pressure, for the hooking up of the pup	966.00	966.00
1	9900893	Valve Force Cable pull-off (for use w/telescopic hoist) installed	518.00	518.00
1	9901197	Valve Force C10190 Pressure Release Valve & Lines, Installed	360.00	360.00
1	9900871	Switch TMTE BODY UP Installed (electric controls only)	182.00	182.00
1	9900884	Sensor Force Low oil indicator system, SLIM-LINE AND CABSHIELD MOUNTED w/light mounted in cab, installed	207.00	207.00
1	9903110	PreCise MRM 6950412 IX-402LS Cellular AVL KIT	695.00	695.00
1	9903112	PreCise MRM 2260025 Std Cellular Antenna EXT PERMANENT MOUNT GSM/GPS	37.00	37.00
1	9903256	PreCise MRM 226006 Interface CABLE, IO, SERIAL, to 5100/6100	9.00	9.00
1	SPECIAL REQUEST	Special Request Charges for: Install air solenoid valve mounted in cab and piped to the tailgate to run a customer supplied tail gate sander on off valve and connected to 5100 control. Hook up valve as you would a pewet	275.00	275.00
1	SPECIAL REQUEST	Special Request Charges for: RUN HOSES AND FITTINGS FOR FRONT BROOM SYSTEM	550.00	550.00
1	9901018	STROBE (2) TIR-3 INSTALLED IN TRUCK GRILL Note: (2) 90° TIR3 ½ amber ½ white LED strobes mounted in the truck grill (PART NO. SSAC2ZCR)	348.00	348.00

Towmaster, Inc.
61381 US Hwy. 12, Litchfield, MN
Phone: 800-462-4517 / 320-693-7900

Truck Equipment - Cutting Edges - Asphalt Repair Equipment

NOTE: If changes are made to an order after a P.O. has been issued, a FEE may be assessed and a revised or new P.O. MUST BE submitted to reflect changes.

Visit us online at www.towmastertruck.com

Accepted By:	Date:

Price:	**$113,841.00**
Discount:	**$0.00**
Other Credit (see above):	**$0.00**
Net Cost:	**$113,841.00**
Sales Tax:	**$0.00**
Other Charge (see	**$0.00**
Freight	**$0.00**
Total:	**$113,841.00**

DAVID DROWN ASSOCIATES

Waconia Office:
2078 Feather Circle
Waconia, MN 55387
Phone: (952) 442-5821
Fax: (952) 442-8838
Email: shannon@daviddrown.com

January 4, 2016

McLeod County
Attn: Pat Melvin, County Administrator
830 11th Street East, Suite 110
Glencoe, MN 55336

RE: City of Stewart - North Connector Road Project

Honorable Commissioners and Administrator Melvin:

Thank you for the opportunity to discuss the North Connector Road Project proposed by the City of Stewart. This important project will serve the largest employer in the southwest portion of the County and reduce the impacts associated with truck traffic on recently reconstructed streets within the City.

Project Background:
Form A Feed, the largest employer in the City of Stewart, recently indicated that they were intending to expand their livestock feed mill facilities and add up to 25 additional employees at salaries ranging from $35,000 - $50,000 per year. As a result of this expansion, an additional 210 truck trips a day would be generated by their Stewart facility. Form A Feed currently generates approximately 100 truck trips a day that utilize local streets through residential areas of the community.

In order to reduce the proposed truck traffic through residential areas, and provide access to additional vacant land that could be developed for industrial purposes, the City of Stewart is proposing to construct a new roadway that will connect Yankee Avenue and McLeod County CSAH 7, both of which are designated truck routes that would provide a more appropriate means of access for Form A Feed and related development (North Connector Street Project).

The City of Stewart wants to encourage the Form A Feed expansion that will lead to additional employment opportunities within the community. The City would also like to implement the proposed North Connector Street Project to minimize the impact of additional truck traffic on residential streets that have been recently reconstructed.

North Connector Street Project:
The North Connector Street Project is presently estimated to cost $1,030,000 (engineer's estimate attached) which includes the acquisition of the necessary right-of-way. The City is intending to fund the project through the following means:

Source:	Amount:
State of MN (BDIP Grant)	$500,000
Right-of-Way Acquisition (Form A Feed)	$100,000
Issuance of G.O. Tax Abatement Bonds (City)	$430,000
Total:	**$1,030,000**

Some of the Form A Feed properties were included in the JOBZ program as a result of a previous expansion project. The City of Stewart is proposing to fund payments on the issuance of $430,000 in General Obligation Tax Abatement Bonds by implementing a tax levy based on the tax base that will be coming out of the JOBZ program after 2016. Form A Feed will be paying an additional $49.317 per year in City and County property taxes following the expiration of the JOBZ program ($40,921 – City and

$8,396 – County). Additionally, Form A Feed will be paying $11,288 in City, County, School, State, and Watershed taxes on the expansion project Form A Feed is proposing.

Based on a bond issue of $430,000 amortized over ten years, the City would be abating (applying to bond payments) approximately $45,000 in taxes each year, **and is requesting that the County consider abating (applying to bond payments) a maximum of $8,000 in property taxes each year for a term of 10-years.** This request is less than the estimated County tax that will be paid by Form A Feed on its JOBZ properties, and the County will benefit immediately from the tax base created by the proposed Form A Feed expansion.

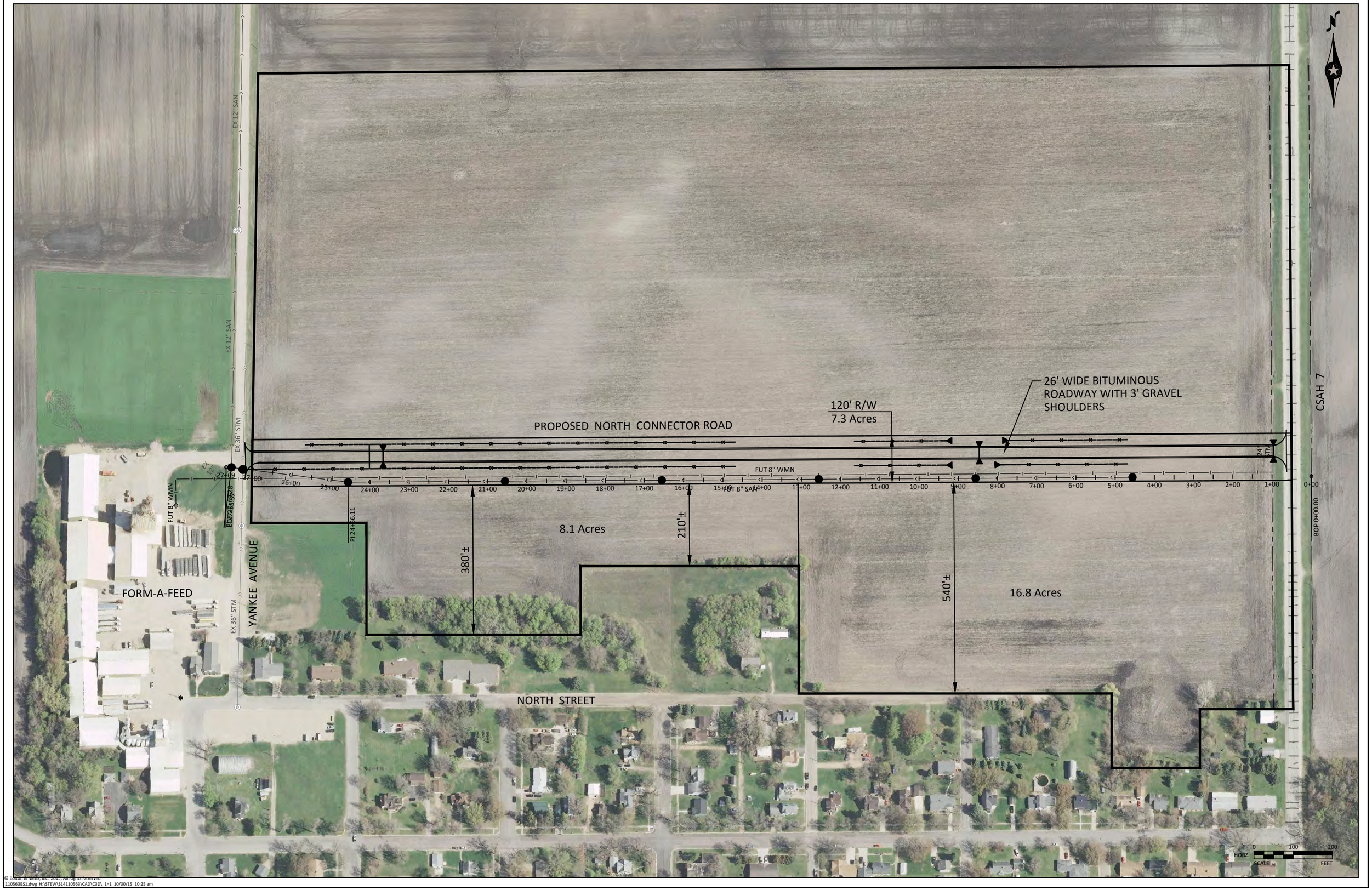
If the County is willing to consider participating in the proposed project through the use of tax abatement, the process would include the following:

Meeting Date:	**Action Required:**
January 19, 2016	County Board calls for public hearing to consider tax abatement request. (11 days published notice required)
February 16, 2016	County Board holds public hearing and considers abatement resolution.

I will be available at the January 5, 2016 work session to discuss this material in detail. Thank you for your time and consideration.

Sincerely,

Shannon Sweeney
David Drown Associates, Inc.



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1105638S1.dwg H:\STEW\S14110563\CAD\C3D\ 1=1 10/30/15 10:25 am

Preliminary Project Cost Estimate
Street Surfacing Improvements
North Connector Road

- north of North Street between Yankee Avenue to CSAH 7
- Bitumiinous Pavement with Aggregate Shoulders

October 27, 2015

H:\STEW\S14110563\3_Design\[2016 North Connector Road PPCE.xls]PPCE New Road to FormAFeed

Item No.	Item Description	Unit	Estimated Unit Price	Estimated Quantity	Estimated Cost
	Surface Improvements				
1	Mobilization & Traffic Control	Lump Sum	$50,000.00	1.0	$50,000.00
2	Common Borrow (LV)	Cubic Yard	$8.00	0	$0.00
3	Common Excavation (P)	Cubic Yard	$7.00	17,600	$123,200.00
4	Geotextile Fabric, Type V	Square Yard	$0.95	9,400	$8,930.00
5	6" Perforated PE Pipe Drain	Linear Foot	$6.50	1,000	$6,500.00
6	Aggregate Shouldering, Class 1 (5")	Ton	$18.00	600	$10,800.00
7	Aggregate Base, Class 7 (12")	Ton	$15.00	5,700	$85,500.00
8	Aggregate Base, Class 5 (8"')	Ton	$16.00	3,820	$61,120.00
9	Type SP 9.5 Wearing Course Mixture (SPWEA240B) (2")	Ton	$82.50	915	$75,487.50
10	Type SP 12.5 Non-Wearing Course Mixture (SPNWB240B) (3")	Ton	$80.00	1,380	$110,400.00
11	Striping, Pavement Markings, Signs	Lump Sum	$5,000.00	1	$5,000.00
12	Silt Fence and Bioroll	Linear Foot	$3.50	5,000	$17,500.00
13	Inlet Protection	Each	$150.00	5	$750.00
14	Permanent Seeding	Lump Sum	$4,000.00	1.0	$4,000.00
	Storm Sewer and Storm Water Management				
15	Centerline Culverts	Linear Foot	$50.00	224	$11,200.00
16	Driveway Culverts	Linear Foot	$25.00	60	$1,500.00
17	Culvert Aprons	Linear Foot	$650.00	6	$3,900.00
18	Driveway Culvert Aprons	Each	$100.00	4	$400.00
19	Rip Rap	Cubic Yard	$50.00	18	$900.00
20	6" and 8" Perforated Filtration Drain	Linear Foot	$12.00	3,800	$45,600.00
21	6" and 8" Filtration Drain Intake/Cleanout	Each	$100.00	15	$1,500.00
22	Storm Manhole	Linear Foot	$300.00	20	$6,000.00
23	Manhole Casting	Linear Foot	$650.00	2	$1,300.00
24	Linear Storm Water Filtration System	Linear Foot	$12.28	3,800	$46,664.00
25	Tile Repair/Replacement	Linear Foot	$20.00	200	$4,000.00
	Subtotal Estimated Construction Costs				$682,151.50
	Contingency For Unforseen and Incidental Items of Work				$68,215.15
	Total Estimated Construction Costs				**$750,366.65**
	Testing, Permits, Legal, Admin, Other Soft Costs (7%)				$52,517.36
	Preliminary, Design, and Construction Phase Engineering (18%)				$135,066.00
	120' Width Right-of-Way Acqisition	Acres	$8,500.00	7.3	$62,050.00
	Total Estimated Project Cost				**$1,000,000.00**

County of McLeod

830 11th Street East
Glencoe, Minnesota 55336
FAX (320) 864-1809

COMMISSIONER RON SHIMANSKI
1st District
Phone (320) 327-0112
23808 Jet Avenue
Silver Lake, MN 55381
Ron.Shimanski@co.mcleod.mn.us

COMMISSIONER DOUG KRUEGER
2nd District
Phone (320) 864-5944
9525 County Road 2
Glencoe, MN 55336
Doug.Krueger@co.mcleod.mn.us

COMMISSIONER PAUL WRIGHT
3rd District
Phone (320) 587-7332
15215 County Road 7
Hutchinson, MN 55350
Paul.Wright@co.mcleod.mn.us

COMMISSIONER SHELDON NIES
4th District
Phone (320) 587-5117
1118 Jefferson Street South
Hutchinson, MN 55350
Sheldon.Nies@co.mcleod.mn.us

COMMISSIONER JOE NAGEL
5th District
Phone (320) 587-8693
20849 196th Road
Hutchinson, MN 55350
Joseph.Nagel@co.mcleod.mn.us

COUNTY ADMINISTRATOR
PATRICK MELVIN
Phone (320) 864-1363
830 11th Street East, Suite 110
Glencoe, MN 55336
Pat.Melvin@co.mcleod.mn.us

MCLEOD COUNTY, MINNESOTA

RESOLUTION NO. 16-CB-08

RESOLUTION APPROVING PROPERTY TAX ABATEMENT FOR CERTAIN PROPERTY LOCATED IN MCLEOD COUNTY

BE IT RESOLVED By the County Board of Commissioners (the "County Board") of McLeod County, Minnesota (the "County") as follows:

Section 1. Recitals.

1.01. The County is considering granting a property tax abatement (the "Abatement") in order to financially assist in the extension of municipal streets in the City of Stewart (the "Project"). The Project shall serve truck traffic generated by FormAFeed, a feed processing business located in the City of Stewart and located on the ("Abatement Property") which is identified by parcel identification numbers 20.050.1070 and 20.067.0070, all pursuant to Minnesota Statutes, Sections 469.1812 through 469.1815, as amended (the "Act").

1.02. Pursuant to Section 469.1813, Subdivision 1 of the Act, if the benefits to the County of the proposed Abatement at least equal the costs to the County of the proposed Abatement, the County may grant an abatement of all or a portion of the taxes imposed by the County on an affected parcel of property.

1.03. The City of Stewart has indicated that the tax abatement requested from the County shall enable the City to improve public safety by re-directing truck traffic from residential streets, and shall increase the longevity of local streets that have been recently reconstructed by decreasing the amount of truck traffic on those same streets.

1.05. On the date hereof, this County Board conducted a duly noticed public hearing on the Abatement, at which the views of all interested persons were heard.

Section 2. Findings.

2.01. This County Board finds and determines that the public benefits to the County from the Abatement will be at least equal to the costs of the Abatement, because (a) the public safety improvements that result from the proposed project are significant and cost effective, and the financial impact to County taxpayers in increasing the longevity of recently reconstructed streets in the City of Stewart exceeds the cost of the County Abatement.

2.02. The County Board finds and determines that the Abatement is in the public interest and confers public benefits for the reasons described in Section 2.01 hereof.

Section 3. Actions Ratified; Abatement Approved.

3.01. The County Board ratifies all actions of the County's staff and consultants in arranging for approval of this Resolution in accordance with the Act.

3.02. Subject to the provisions of the Act, the Abatement is approved and adopted subject to the following terms and conditions:

(a) The term "Abatement" is further defined to mean the County's share of the real property taxes generated from the Abatement Property, in the amounts described in this Section:

(i) The County shall abate a portion of its respective share of the taxes received from the FormAFeed parcels described above (the "Abatement Property"), commencing with taxes payable during the year 2017 (the "County Abatement"). The County shall annually abatement a maximum of $8,000 in property taxes. The abatement term shall be for 10-years. The total abatement amount shall not exceed $80,000.

(ii) Notwithstanding anything to the contrary herein, the Abatement payable on any August 1 and subsequent February 1, combined, will not exceed the amount produced by extending the County's total local tax rate for the applicable year against the total net tax capacity released from the JOBZ Program in 2016 for the Abatement Property.

(iii) In accordance with Section 469.1813, Subdivision 8 of the Act, in no year shall the Abatement, together with all other abatements approved by the County under the Act and paid in that year, exceed the greater of 10% of the County's net tax capacity for that year or $200,000.

(b) This Resolution may be modified only with the prior written approval of the County, and any modification is subject to Section 469.1813, Subdivision 7 and Section 469.1814, Subdivision 4 of the Act.

(c) In accordance with Section 469.1815 of the Act, the County will add to its levy in each year during the term of the Abatement the total estimated amount of current year Abatement granted under this Resolution.

3.03. The County Board Chair and the County Administrator are authorized and directed to execute and deliver any agreements, certificates or other documents that the County determines are necessary to implement this Resolution.

Adopted by the County Board of McLeod County, Minnesota, this 16th day of February, 2016.

_____

McLeod County Board Chair

ATTEST:

_____

County Administrator

Minnesota Counties Computer Cooperative

Minnesota Counties Computer Cooperative

(651) 917-6969 Fax: (651) 917-6989 www.mnccc.org

Invoice Due Date February 25, 2016

INVOICE

Please send payment to:
MCCC, MI 33
PO Box 1150
Minneapolis, MN 55480-1150

INVOICE NO: 2Y1601520

INVOICE DATE: 1/26/16

AMOUNT DUE: 10,000.00

CUSTOMER:
MCLEOD COUNTY
IS Manager
830 11th Street E., Suite 111
GLENCOE, MN 55336

I declare under penalty of law that this amount is true and correct and that not part of it has been paid.

Lisa Christine Meredith, Executive Director

Item/Description	Units	Price/Unit	Net
2016 - Xerox New Tax/Cama Project Management fund ($5,000/per system project costs)	2.00	5,000.00	10,000.00

Approved at today's Xerox New Project Management team Conference call

Notice:
As allowed by our bylaws and approved at the Executive Board Meeting on 10/09/03
1% interest will be applied to any invoices that are over 60 days effective 1/01/04.

Total: 10,000.00

Please return this portion with payment.

Minnesota Counties Computer Cooperative
(651) 917-6969 Fax: (651) 917-6989 www.mnccc.org

CUSTOMER:
MCLEOD COUNTY
IS Manager
830 11th Street E., Suite 111
GLENCOE, MN 55336

INVOICE NO: 2Y1601520

INVOICE DATE: 1/26/16

AMOUNT DUE: 10,000.00

Please send payment to:
MCCC, MI 33
PO Box 1150
Minneapolis, MN 55480-1150

AMOUNT ENCLOSED:

McLeod County Auditor-Treasurer

Cindy Schultz Ford

2391 Hennepin Ave. N.
Glencoe, MN 55336
(320) 864-1210 office (320) 864-3268 fax
E-mail: cindy.schultz@co.mcleod.mn.us

STATE OF MINNESOTA

COUNTY OF MCLEOD

BOARD OF COMMISSIONERS

MCLEOD COUNTY DITCH AUTHORITY

In the matter of
County Ditch No. 26 and
County Ditch No. 27
Repair Petition

NOTICE OF HEARING
ON REPAIR REPORT
PURSUANT TO 103E.715

WHEREAS, on the 7th day of April, 2015, a Petition to Repair County Ditch No. 26 and County Ditch No. 27 was filed in the office of the County Auditor-Treasurer of McLeod County, Minnesota, and

WHEREAS, Chuck Vermeersch of SEH, Inc. was appointed on April 7, 2015 as the Engineer in said proceedings and ordered to examine said drainage system and make a repair report and file his report thereon with the office of the County Auditor-Treasurer of McLeod County, and

NOW, THEREFORE, TAKE NOTICE, that the hearing on said repair report will be held before the County Ditch Authority on **Tuesday, February 16, 2016 at 10:30 a.m.** in the **McLeod County Courthouse** (lower level County Board Room), **830 11th Street East**, in the **City of Glencoe, Minnesota.** Items to be discussed and considered include:

1. Receive the Repair Report.
2. Determine Findings.
3. Consider Ordering the Repair.
4. Other items of business as deemed necessary.

All interested persons are invited to attend and be heard in this matter.

If you have any questions, please contact the McLeod County Auditor-Treasurer's Office at 320-864-1210 or cindy.schultz@co.mcleod.mn.us.

Dated: February 1, 2016

Cindy Schultz Ford

Cindy Schultz Ford, McLeod County Auditor-Treasurer

Posted: February 1, 2016
Published: February 3 and 10, 2016
Mailed: February 5, 2016
{M.S. 103E. 715, subd 3}

PROJECT COST ESTIMATE
ENGINEER'S REPORT
MCLEOD COUNTY DITCH NO. 26 AND 27
FEBRUARY 1, 2016

COUNTY DITCH NO. 26

Item No.	Description	Qty	Unit	Unit Price	Total Price
1	Remove Sediment from Ditch	6,700	L.F.	$1.75	$11,725.00
2	Spoil Pile Leveling	1	L.S.	$6,500.00	$6,500.00
3	Crop Damages	11	Acre	$400.00	$4,400.00
4	Turf Restoration on Side Slopes	1	Acre	$3,000.00	$3,000.00
5	4" to 6" Tile Outlet Replacement	2	Each	$500.00	$1,000.00
6	8" to 12" Tile Outlet Replacement	7	Each	$650.00	$4,550.00
7	Clearing and Grubbing 15" Tree or Smaller	24	Each	$100.00	$2,400.00
8	Clearing and Grubbing 16" Tree or Larger	18	Each	$175.00	$3,150.00
9	Grass Buffer	5	Acre	$2,500.00	$12,500.00
10	Bury Rock Piles	1	Each	$1,500.00	$1,500.00
11	Side Slope Repair	2	Each	$500.00	$1,000.00
12	Rip Rap	25	Ton	$80.00	$2,000.00
	CONSTRUCTION COST FOR CD 26				**$53,725.00**

COUNTY DITCH NO. 27

Item No.	Description	Qty	Unit	Unit Price	Total Price
1	Remove Sediment from Ditch	21,800	L.F.	$2.25	$49,050.00
2	Spoil Pile Leveling	1	L.S.	$18,500.00	$18,500.00
3	Crop Damages	60	Acre	$400.00	$24,000.00
4	Turf Restoration on Side Slopes	2	Acre	$3,000.00	$6,000.00
5	4" to 6" Tile Outlet Replacement	6	Each	$500.00	$3,000.00
6	8" to 12" Tile Outlet Replacement	12	Each	$650.00	$7,800.00
7	15" to 18" Tile Outlet Replacement	3	Each	$900.00	$2,700.00
8	Clearing and Grubbing 15" Tree or Smaller	44	Each	$100.00	$4,400.00
9	Clearing and Grubbing 16" Tree or Larger	33	Each	$175.00	$5,775.00
10	Grass Buffer	17	Acre	$2,500.00	$42,500.00
11	Bury Rock Piles	1	Each	$1,500.00	$1,500.00
12	Side Slope Repair	4	Each	$500.00	$2,000.00
13	Rip Rap	50	Ton	$80.00	$4,000.00
	CONSTRUCTION COST FOR CD 27				**$171,225.00**

PROJECT RELATED EXPENSES

Administrative and Legal	$2,500.00
Topographic Surveying	$16,800.00
Report and Attend Public Hearing	$15,650.00
Plans, Specifications, Permit(s) Submittal and Bidding	$16,800.00
Construction Administration	$7,500.00
Construction Staking	$8,100.00
Construction Observation	$14,500.00
TOTAL ESTIMATED PROJECT RELATED EXPENSES	**$81,850.00**
TOTAL ESTIMATED CONSTRUCTION COSTS FOR CD 26 & 27	**$224,950.00**
TOTAL ESTIMATED PROJECT COST	**$306,800.00**

MCLEOD COUNTY BOARD
AGENDA REQUEST

Board meeting date:	2/16/16	Originating department:	Planning & Zoning
Consent or regular agenda:	Regular	Preferred agenda time:	10:45
Amount of time needed:	30 minutes	Funding source (if applicable):	_____
Contact person for more info:	Larry Gasow	Are funds in Dept. budget:	_____
Representative (present at the meeting to discuss):	Larry Gasow X-1218		

MOTION REQUESTED:
CleodSun LLC on behalf of SunShare, LLC requests approval of Conditional Use Permit 16-01 as an Essential Service on property owned by Steinkraus Lester Prairie LLC for the purpose of a Community Solar Garden. SunShare, LLC is planning an up to a 3 Megawatt (MW) garden upon approval by Xcel Energy of their application to provide them with renewable energy on the Xcel Energy power grid. The proposed Solar Garden meets all setbacks and requirements of the Zoning Ordinance. The property will be fenced for security and safety reasons. Appropriate applications shall be submitted to local and State Agencies. This property is located within approximately 25 AC parcel in NW ¼ of NE ¼ of Section 32, Winsted Township.

JUSTIFICATION FOR MOTION:

Winsted Township did not make recommendation of the proposed application at their regular meeting on January 14, 2016 due to the request for additional information, which was provided on January 22, 2016.

On January 27, 2016, the Planning Advisory Committee recommended approval by majority vote being taken. being In Favor – 2; being In Opposition – 1, with the following conditions being applied:

1) Proof of Insurance shall be provided to the Zoning Office prior to any permits being issued.
2) A Bond or Letter of Credit in the amount of $60,000 shall be submitted to the Zoning Office prior to any permits being issued. (3 MW @ $20,000 each = $60,000)
3) Copy of MnDOT proposal granting access to utilize the gravel access road to site location shall be provided to the Zoning Office prior to any permits being issued.
4) Xcel Energy shall check for stray voltage on site and neighboring sites on a monthly basis for one year. A copy shall be provided to the Zoning Office.
5) A contact person for noxious weeds and other concerns shall be identified by a placard sign at the sight with contact name and phone number.
6) A contact name shall be provided to the Zoning Office for decommission and reclamation once the essential service is no longer in use.
7) A landscape buffer plan and vegetative management plan shall be provided to the Zoning Office.
8) A Wetland Delineation shall be performed by contacting Environmental Services Officer.
9) Applicant shall meet all NPDES Permit requirements.
10) Agricultural fencing with two strands barbed wire shall be installed for site safety and security.

STAFF REPORT

TO:	McLeod County Planning Commission
Prepared By:	Larry Gasow
Date:	January 20, 2016
Permit: CUP #16-01	**Meeting Date: January 27, 2016**

GENERAL INFORMATION

Applicant:	CLeodSun, LLC On behalf of SunShare, LLC 609 South 10th St, Suite 210 Minneapolis, MN 55404 612/701-4855
Property Owner:	Merle Steinkraus 1800 Lake Lucy Rd Excelsior, MN 55331 @ Steinkraus Lester Prairie LLC 112 E 5th St. #101 Chaska, MN 55318
Property Site:	5383 Hwy 7 Lester Prairie, MN 55354 PID #14.032.0950
Requested Action:	Application for a conditional use permit for Essential Services of a 3 MW community solar garden array system connected to the public power grid of Xcel Energy. The purpose of the essential services is for electrical generation through solar energy.
Purpose:	To operate potentially a 3 MW Community Solar Garden that will be placed on approximately 25 acres. The panel posts will be pile driven into the ground approximately 8' to 12' without the need for concrete. The area will have a 6' chain link fence and gravel access for maintenance trucks.
Existing Zoning:	Agricultural.
Location:	NW ¼ of NE ¼ of Section 32 within Winsted Township.

Size:	3 megawatt (MW) array within the 25 acre tract.
Existing Land Use:	Agricultural.
Surrounding Land Use and Zoning:	"A" Agricultural, residential and farmstead building sites.
Applicable Regulations:	Section 18, Subdivision 4
History:	The landowner is an absentee landowner with a building site and bare farmland.

SPECIAL INFORMATION

Transportation:	St Hwy #7
Physical Characteristics:	Existing building site and agricultural land.

ANALYSIS

The Winsted Town Board did not sign the CUP form as they felt that not enough information was given as a project to both the Board and neighboring landowners. This 25 acre tract is part of a larger agricultural tract with an additional building site tract. CLeodSun with SunShare would like to contribute to the growing need of "Green Energy" and will be run to the electrical grid of Xcel Energy. This would be similar to the other Electrical Coops within McLeod County which have their customers invest in electrical generating solar "fields" or "gardens" to place on the grid. Solar gardens make application to Xcel Energy to supple electricity to the substation, each site is limited to the amount of which solar power or wind generation can be received. CLeodSun has made application but have not be notified of acceptance at this time. This would be similar but smaller in size and production to the future solar array field being proposed by Geronimo to the east of this proposed site by 3 miles. Traffic and neighbors should not be affected other than a visual change in the landscape. Should not be a nuisance or negative affect on health safety or welfare with the public. The unfounded claim is that there are diminished residential property values. An NPDES permit will be applied for to control run off from the site. The site will be graded as to not exceed more than a 3% slope and vegetation will be grown for ground cover.

RECOMMENDATIONS

Staff has no objections but as a commission will have to evaluate the concerns of the Township and surrounding land owners regarding this application. If approved there should be similar conditions placed on this permit and with other solar gardens within McLeod County and the State of Minnesota. They are as follows:

1. Proof of Insurance shall be provided to the Zoning Office prior to any permits being issued.
2. A Bond or Letter of Credit in the amount of $20,000 per megawatt. (3 MW @ $20,000 = $60,000) shall be provided to the Zoning Office prior to any permits being issued.
3. Contact person for noxious weed control and other concerns shall be identified.
4. A landscape buffer plan and vegetative management plan shall be provided to the Zoning Office.
5. Applicant shall meet all NPDES Permit requirements.
6. Agricultural fencing with two strands of barbed wire shall be installed for site security.

Minnesota Department of Transportation
District 8 Headquarters
2505 Transportation Road
Willmar, MN 56201

Office: 320-231-5195
Fax: 320-214-6305
800-657-3792

January 14, 2016

Larry Gasow
Zoning Administrator
McLeod County
Courthouse - 830 11th Street E, Suite 113
Glencoe, MN, 55336

RE: Conditional Use Permit – CleodSun LLC
Trunk Highway (TH) 7; Control Section 4302, 4.5 miles east of Silver Lake
Approximately R.P. 155.44 – R.P. 155.69, south side of TH 7

Dear Mr. Gasow:

Thank you for notifying the Minnesota Department of Transportation (MnDOT), District 8, of the Conditional Use Permit application filed by CleodSun LLC on property owned by Steinkraus Lester Prairie LLC for a Community Solar Garden. The proposed business would be located on the south side of TH 7, approximately 4.5 miles east of Silver Lake. Upon review of the application, MnDOT offers the following comments:

1. To obtain access to TH 7 the property owner is required to coordinate with MnDOT District Staff and submit an Access Permit Application (TP -1721). The access permit and other applicable permit applications can be found at the following web site http://www.dot.state.mn.us/utility/forms.html or contact Geri Vick, Permit Agent, at 320-214-6364, Geri.Vick@state.mn.us .
2. MnDOT views solar generating projects as it would any other private commercial venture and does not consider a solar generating project to be a public utility for transportation purposes. MnDOT allows private parties, by permit, to place connecting lines across trunk highway rights of way, but does not allow private parties to place such facilities longitudinally along trunk highways. Any associated electric cable/feeder lines that run along a trunk highway right of way would need to be permitted through a municipal, cooperative or investor owned electric service provider.
3. MnDOT requests that a drainage permit be completed if any changes to the current hydraulic flows are planned onto or in the trunk highway right of way.
4. The Conditional Use Permit should include language specifying that the Permittee shall obtain all relevant permits from MnDOT relating to access to the project, drainage, as well as installation of facilities that occupy portions of trunk highway right of way.
5. With the setbacks that you have shown, MnDOT doesn't perceive an issue with snow problems related to our trunk highway.

6. Based on the application, MnDOT does not perceive an issue with glare from the facility panels.

MnDOT appreciates the opportunity to comment on any site development plans or zoning requests on properties adjacent to state highways. If you have any questions or concerns, please contact me at 320-214-6364,

Sincerely,

Geri Vick

Geri Vick
Engineering Specialist
Planning

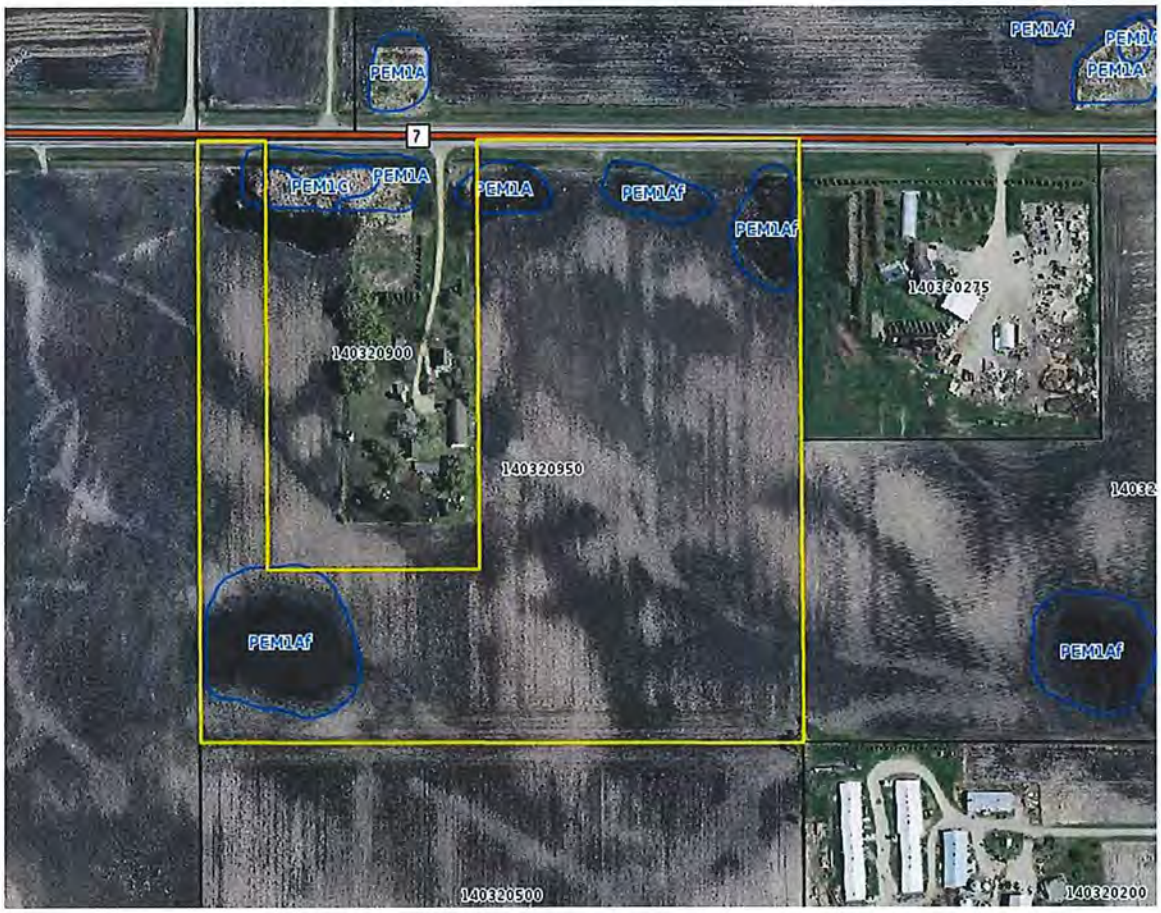
cc: Lindsey Knutson – MnDOT District 8 Planning Director

MCLEOD COUNTY
ENVIRONMENTAL SERVICES
STAFF REPORT

Prepared by: Roger Berggren Date: January 20, 2016

Applicant: CleoSun LLC

Issue: CUP For Community Solar Garden



Information:

The applicant is applying for a Conditional Use Permit to construct a community Solar Garden. According to the NWI Map, soil survey, and an aerial photo review there appears to be some questionable areas that may be considered wetlands in the proposed construction site. The above map shows some areas of concern where there may be wetlands that are protected.

SunShare

THE POWER TO CHOOSE

Conditional Use Permit Application

December 16, 2015

McLeod County
Planning Commission Request
Attention: Larry Gasow, Zoning Administrator
830 11th Street E, Suite 113
Glencoe, MN 55336

RE: Application for a Conditional Use Permit for a Community Solar Garden within McLeod County on property owned by Steinkraus Lester Prairie LLC (PID# 14.032.0950).

Dear Larry,

Attached you will find an application for a Conditional Use Permit (CUP) to construct a Community Solar Garden within McLeod County. The request is being made by CLeodSun LLC on behalf of SunShare, LLC.

In 2013, Xcel Energy was directed by the State of Minnesota to obtain 1.5% of its energy from solar by the year 2020. The development and operation of this Community Solar Garden will aid Xcel Energy in complying with this requirement. SunShare, LLC is planning an up to 3 MW garden that will allow Xcel ratepayers, including businesses, residents, government entities and schools, in the McLeod County to choose solar power and save money on their electricity bill.

The property has been identified and is under contract. The proposed site encompasses approximately 25 acres and is currently used for agricultural purposes.

This property was chosen based on the following criteria:

- Consideration of applicable zoning and permit requirements;
- A willing property owner.
- Absence of topographic obstructions such as buildings, hills, vegetation, etc.;
- Proximity to 3 phase power and an interconnection to the Xcel Energy distribution grid.

The proposed Solar Garden meets all setbacks and requirements of the Zoning Code. The property will be fenced for security and safety reasons. SunShare, LLC has also submitted the appropriate applications to Xcel and other regulatory bodies.

Conditional Use Permit Application

The McLeod County Conditional Use Application, Fees, and required submittal materials are attached along with several Exhibits describing, in detail, the Conditional Use Permit proposal. The Exhibits included are as follows:

Exhibits to Application:

- Exhibit A: McLeod County Conditional Use Application Form
- Exhibit B: Introduction to Community Solar and SunShare
- Exhibit C: Conditional Use Application Requirements
- Exhibit D: Site Maps
- Exhibit E: Proposed Conditions of Approval

SunShare, LLC hopes this correspondence and enclosures explain our application and address the requirements of McLeod County. Should you have any questions regarding the attached application for a Conditional Use Permit, please feel free to contact me at 612-701-4855.

SunShare, LLC appreciates the assistance that we have received from you and your staff and we look forward to working with you to better serve the public in this area. Thank you in advance for your consideration of this matter.

Sincerely,

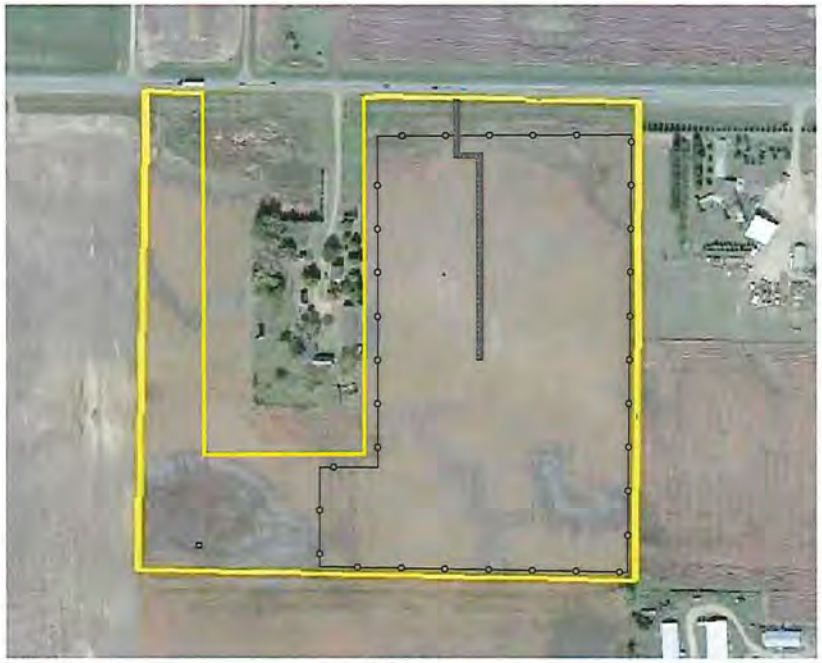
Chuck Beisner
cbeisner@mysunshare.com
612-701-4855

PERMIT SET
CLEODSUN COMMUNITY SOLAR GARDEN
5833 HWY 7, LESTER PRAIRE, MN 55354

VICINITY MAP

SHEET INDEX;

Sheet 1: COVER SHEET, EXISTING CONDITIONS
Sheet 2: PROPOSED DESIGN SITE PLAN
Sheet 3: RACKING AND FENCE DETAILS



SITE PLAN

Parcel Number(s): 14.032.0950

Legal Description:

Approximately 25 acres within the Northwest Quarter of the Northeast Quarter of
Section 32, Township 117 North, Range 27 West, EXCEPT the East 464.00 feet of the
West 612.00 feet of the North 940 feet thereof, Mcleod County, Minnesota

DEVELOPER
SunShare, LLC
609 S 10th Street, Suite 210
Minneapolis, MN 55404

CONTRACTOR
Mortenson Construction
700 Meadow Lane North
Minneapolis, MN 55422

SunShare
THE POWER TO CHOOSE
1441 18th Street, Suite 400 | Denver, CO 80202

CLEODSUN SOLAR GARDEN

5833 HWY 7
LESTER PRAIRIE, MN 55354
Project # 32010200

DESIGNER: VI
REVIEWER: JPL
DATE: 11/30/2015

Tilt Angle: 25° | Azimuth:180°

Power Output (AC): **3.0** MW

Module: (12,960) @ 310 W

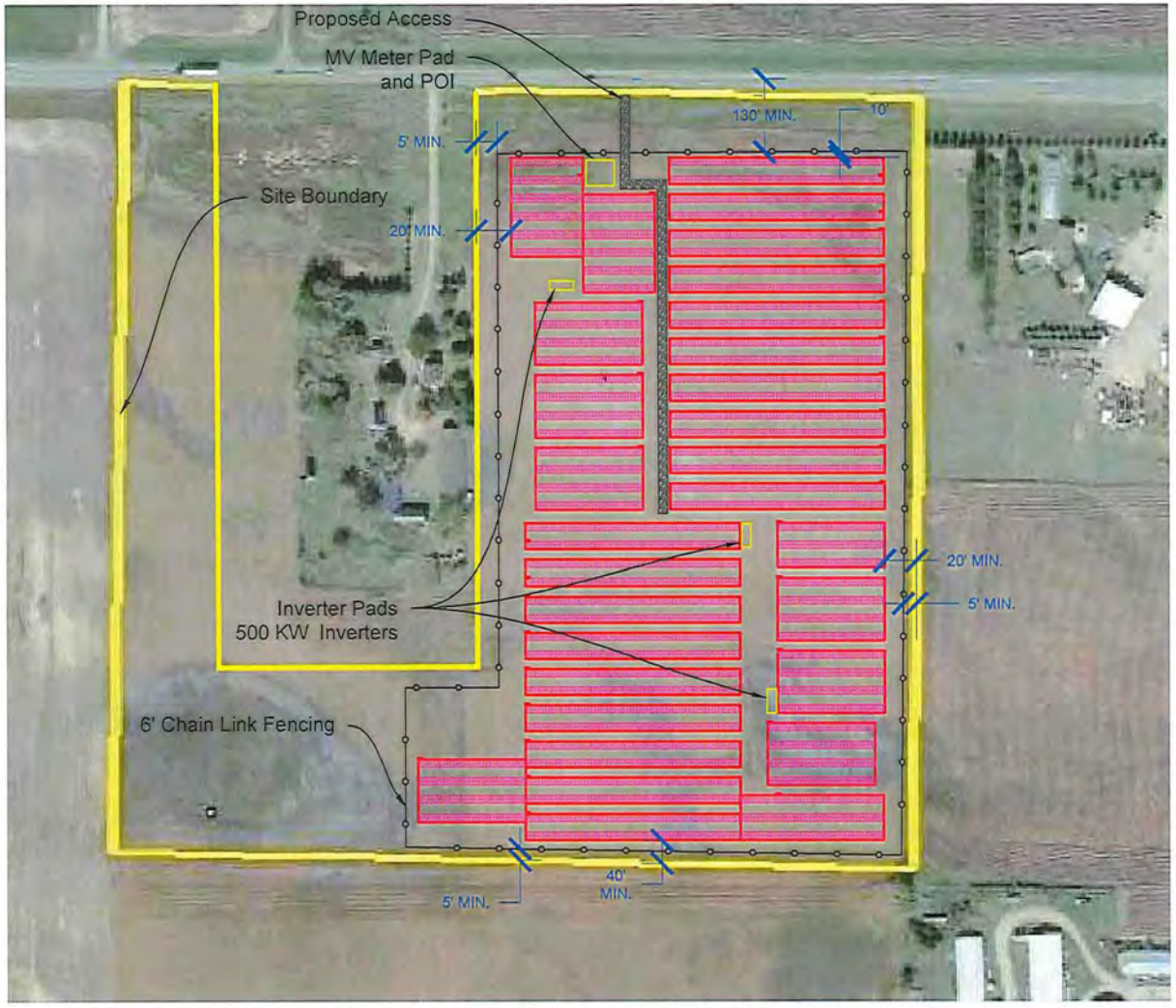
Inverter: (6) @ 500 KW

NOT FOR CONSTRUCTION

SCALE: Scale: 1/6" = 1'-0"

COVER SHEET

PV-00



1 Site Plan

Scale: 1/6" = 1'-0"

SunShare
THE POWER TO CHOOSE
1441 18th Street, Suite 400 | Denver, CO 80202

CLEODSUN SOLAR GARDEN

5833 HWY 7
LESTER PRAIRIE, MN 55354
Project # 32010200

DESIGNER: VI
REVIEWER: JPL
DATE: 11/30/2015

Tilt Angle: 25° | Azimuth:180°

Power Output (DC): **3.0** MW

Module: (12,960) @ 310 W

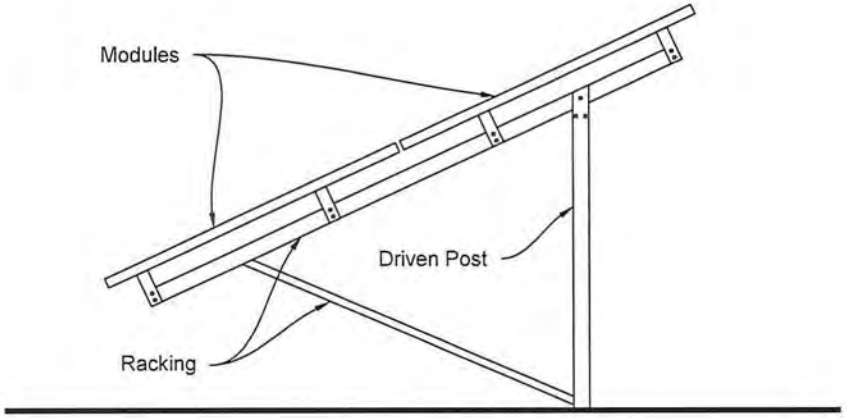
Inverter: (6) @ 500 KW

NOT FOR CONSTRUCTION

SCALE: Scale: 1/6" = 1'-0"

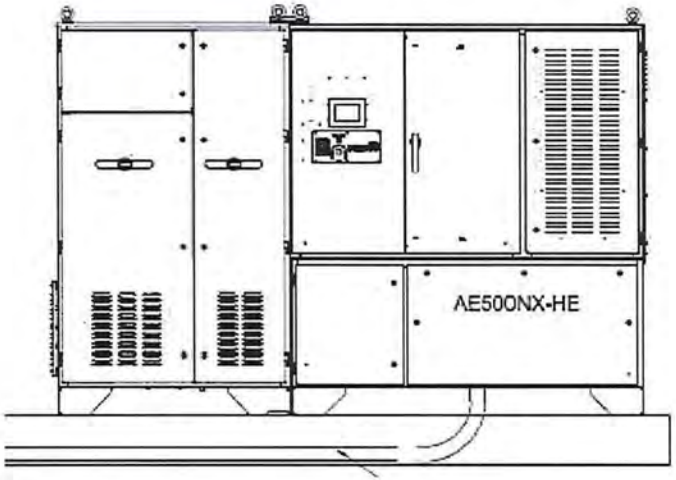
PRELIM SITE PLAN

PV-01



1 Racking Side Elevation

Scale: NTS



2 Typ. Inverter Elevation

Scale: NTS

3 Typ.Chain Link Fence

Scale: NTS

SunShare
THE POWER TO CHOOSE
1441 18th Street, Suite 400 | Denver, CO 80202

CLEODSUN SOLAR GARDEN

5833 HWY 7
LESTER PRAIRIE, MN 55354
Project # 32010200

DESIGNER: VI
REVIEWER: JPL
DATE: 11/30/2015

Tilt Angle: 25° | Azimuth:180°

Power Output (AC): **3.0** MW

Module: (12,960) @ 310 W

Inverter: (6) @ 500 KW

NOT FOR CONSTRUCTION

SCALE: Scale: NTS

PRELIM SITE PLAN

PV-02

Exhibit B: Introduction to Community Solar and SunShare

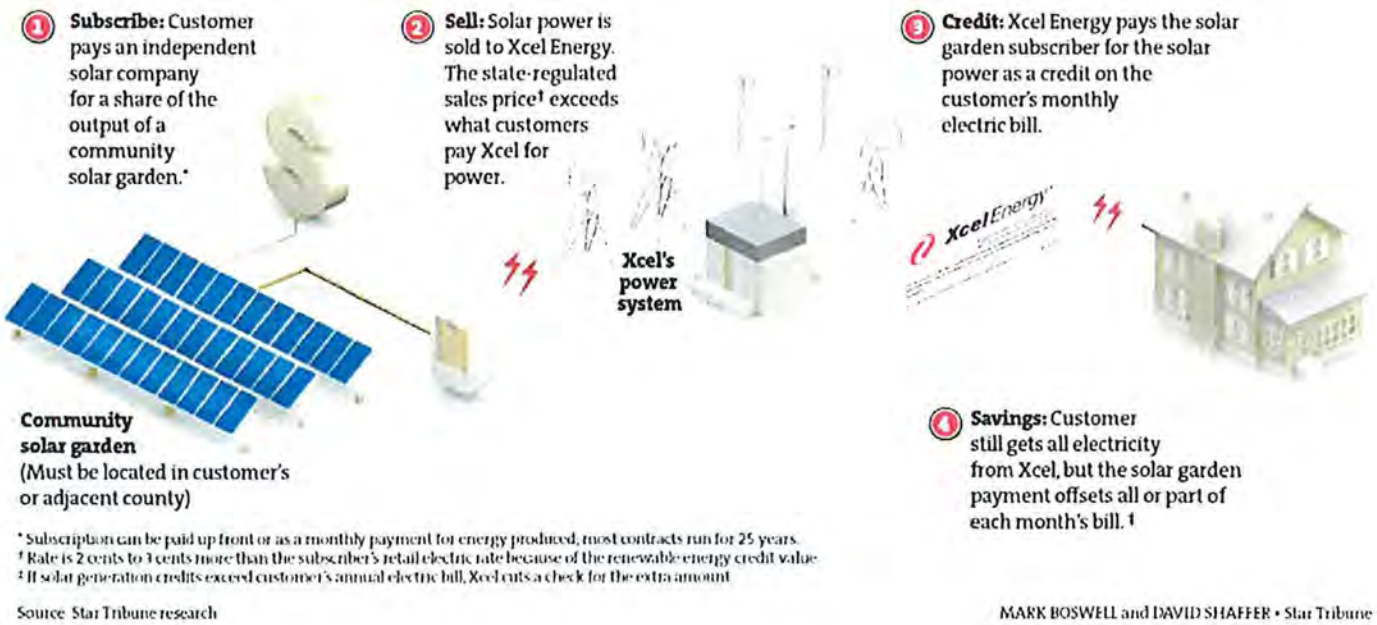
SunShare, LLC
609 South 10th Street, Minneapolis, MN 55404

Conditional Use Permit Application

What is Community Solar?

In 2013, the Minnesota State Legislature passed a landmark Community Solar Garden law that established a new market in the solar industry, providing Xcel Energy customers with additional energy choices.

Community Solar Gardens are field installations of solar panels connected directly to Xcel Energy's distribution grid. Residents, businesses, and governmental customers can opt to use the solar energy from those panels to offset their electricity bill instead of installing panels on their property. It works much the same way as putting a rooftop solar system on a house. This provides a viable alternative for those who would like to use solar power but cannot install a rooftop system. The following image, published by the Star Tribune, depicts how the program works.



* Subscription can be paid up front or as a monthly payment for energy produced, most contracts run for 25 years.
† Rate is 2 cents to 3 cents more than the subscriber's retail electric rate because of the renewable energy credit value.
‡ If solar generation credits exceed customer's annual electric bill, Xcel cuts a check for the extra amount.

Source: Star Tribune research

MARK BOSWELL and DAVID SHAFFER • Star Tribune

SunShare, LLC
609 South 10th Street, Minneapolis, MN 55404

Conditional Use Permit Application

What Does a Solar Garden Look Like?

It is best to look at a picture to understand what a solar garden looks like.

SunShare's solar gardens use photovoltaic technology. The primary raw materials used in this type of module technology consist of but are not limited to aluminum, glass, silicon, trace amounts of phosphorous, boron, silver, and copper. Solar modules will be UL listed, CEC listed, and approved for use by the National Electrical Code (NEC). The panels are dark blue, absorbing as much light as possible in order to convert it into electrical energy. They are coated with an anti-reflective technology to enhance their ability to capture sunlight. People tend to worry about glare from these systems, but with this technology it is really not a problem. Many solar installations have been completed at airports. The photo below is of a solar installation at the Indianapolis Airport.

Conditional Use Permit Application

Each solar module is composed of multiple panels and the modules will be attached to the ground surface using a fixed racking system. Each row of modules will be spaced approximately 15 feet apart and reach about 8.5 feet in height. The system is made of steel vertical posts installed directly into the ground without the use of concrete foundations. Each post will penetrate approximately 8 – 12 feet into the ground. We make every effort to avoid drain tile, working with all stakeholders to identify tile lines and ensure that drainage will not be negatively impacted by our project. One way to further avoid negative drainage impacts is to minimize grading, which we are able to do by following the contours of the land. The following image shows how the modules can do that.

SunShare, LLC
609 South 10th Street, Minneapolis, MN 55404

Through these measures, and by planting a low-growth vegetative ground cover underneath the panels, our systems often reduce surface water runoff relative to the previous land use. By hosting a community solar garden, your community can not only benefit from locally generated power, but can take a step toward improving local water quality, something all Minnesotans appreciate.

Who is SunShare?

SunShare was one of the first community solar developers in the country, pioneering the development of this concept in Colorado and Minnesota. Our customers are residents, community leaders, renowned institutions, and local businesses. Our appeal to the residential customer base sets us aside from our competition - we have hundreds of homeowners participating in each of our current Solar Gardens and have consistently sold out our Solar Gardens before construction begins, an accomplishment no other Community Solar company can claim.

We have a local presence in Minnesota, with an office located in downtown Minneapolis and a strong leadership team, comprised of experienced renewable energy developers. This experience is further bolstered through our partnership with Mortenson Construction. Mortenson was incorporated in Minneapolis, Minnesota in 1954. Today, Mortenson has grown to over 2,100 team members with project operations across 48 states and select international locations. Mortenson has been ranked as the nation's 5th largest solar EPC contractor and has the breadth of experience needed to build successful Community Solar Gardens in Minnesota.

Exhibit C: Conditional Use Application Requirements

SunShare, LLC
609 South 10th Street, Minneapolis, MN 55404

Conditional Use Permit Application

Requirements for a Conditional Use Permit Application

1.) Legal description of the property

The Northwest Quarter of the Northeast Quarter of Section 32, Township 117 North, Range 27 West, EXCEPT the East 464.00 feet of the West 612.00 feet of the North 940 feet thereof, McLeod County, Minnesota

2.) Site plan drawn to scale showing parcel and building dimensions

See Exhibit D

3.) Location of all buildings and their square footage

See Exhibit D

4.) Curb cuts, driveways, access roads, parking spaces, off-street loading areas and sidewalks

See Exhibit D. There will be minimal traffic at the site, estimated at 2-3 personal vehicles visiting the site quarterly and one Xcel service truck visiting the site as needed.

5.) Landscaping and screening plans

` The site will be screened with a 6' chain link fence for security purposes.

6.) Drainage plan

Our engineering contractor will develop a detailed Stormwater Pollution Prevention Plan (SWPPP) and Erosion Control Plan prior to the start of construction that satisfies all local, state, and federal requirements. The SWPPP will include a summary of the general construction activity, what the receiving waters are, storm water mitigation and management measures, any wetland impact, project plans and specifications, temporary erosion prevention measures, temporary sediment control measures, inspection and maintenance activities, pollution prevention management measures, and final stabilization. Any hazardous or toxic materials brought on site will be stored, contained, and secured in compliance with the project Stormwater Pollution Prevention Plan (SWPPP) and section IV.F of the MPCA NPDES Construction General Permit MN R100001 and other applicable local and state permits. Additionally, industry standard Best Management Practices (BMPs) will be put in place; typical solar construction BMPs may include as appropriate, but are not limited to: run off control, solid waste control, retention ponds, vegetative ground cover, fiber rolls, silt fences, erosion blankets, etc.

The project will include both a temporary and permanent Erosion Control Plan (ECP). Erosion Control. BMPs may include minimizing amount of exposed soil, exposed soil areas within 200 feet of protected water to have temporary erosion protection, normal wetted perimeter of drainage ditch on site to be stabilized, no unbroken slope lengths greater than 75 feet for slopes of grade 3:1 or steeper, use of erosion blankets or vegetative ground cover etc.

Conditional Use Permit Application

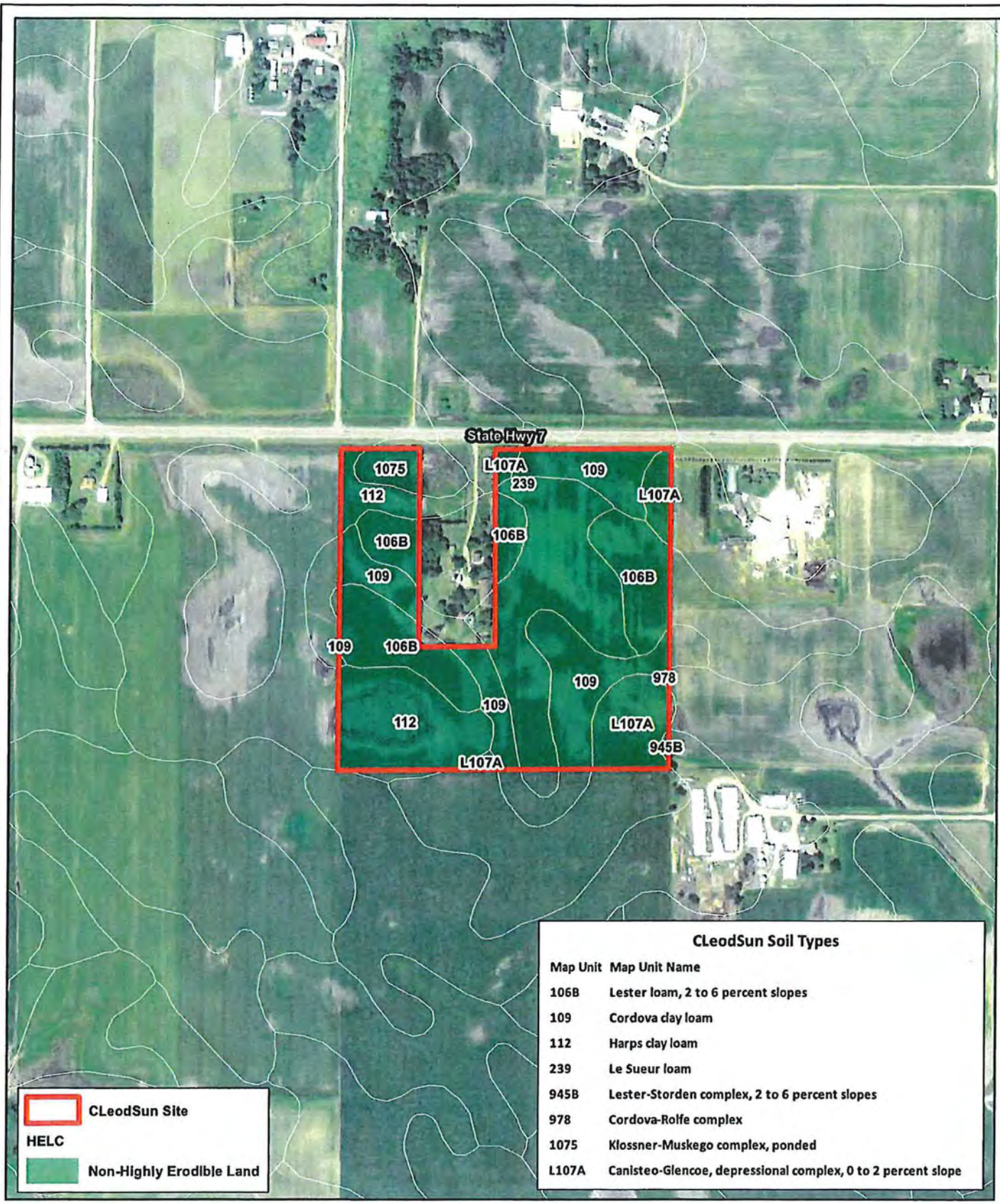
7.) Sanitary sewer and water plan with estimated use per day

The proposed conditional use will not require any sewer or water.

8.) Soil type

See Exhibit D for a soils map of the site.

Exhibit D: Site Maps



Document Path: K:\02977-140\GIS\Maps\CLMSoils.mxd

Figure 8: *Soils*

CLeodSun Site:

Section 32, T117N R27W

Winsted Township, McLeod County, MN

WSB #: 02977-140

N

0 500 Feet

WSB & Associates, Inc.

Exhibit E: Proposed Conditions of Approval

SunShare, LLC
609 South 10th Street, Minneapolis, MN 55404

Conditional Use Permit Application

Proposed Conditions of Approval

1) Any required building permits must be obtained prior to construction of the Facility.
2) Any grading or filling must be done in accordance with the McLeod County Guidelines including the submittal and approval of a Grading and SWPPP plan.
3) All Federal, State and Wabasha County wetland requirements be complied with at all times.
4) Applicant, as used in this Conditional Use Permit to refer to CLeodSun LLC, shall also include its successors and assigns. Upon written notice to the County, this Conditional Use Permit, including all rights and obligations herein, may be assigned, in whole or in part, to any Applicant affiliate and any party with experience owning and operating energy generation or other utility infrastructure facilities. Assignment to any other party shall require consent by the County, such consent not to be unreasonably withheld.

Morris Electronics
511 Atlantic Ave., Morris, MN 320-589-1781

January 21, 2016

Morris Electronics would like to offer you the following options for Zix service.

Option 1 –

If you join our cluster at the state hub in Willmar, we would charge $27.50 per seat for a one year contract. For 200 seats this would be $5,500 per year.

Option 2 –

If you join our cluster at the state hub in Willmar, we would charge $25.00 per seat for a three year contract. For 200 seats this would be $5,000 per year.

Option 3 –

Physical device and 200 seats for $10,000 per year.

With all options there would be some server set up. This would cost a onetime fee of $750 to $1,000. Shawn would work with you and get this set up and implemented. Please let me know if you have any questions, would like to order or need anything else.

Thank you,

Cora J. Pry

Manager

Morris Electronics

320-208-1528

Vincent Traver

From: Ryan Matthews <rmatthews@zixcorp.com>
Sent: Tuesday, January 26, 2016 8:06 AM
To: Vincent Traver
Subject: RE: McLeod County | ZixCorp renewal

This message was sent securely using ZixCorp.

Good morning Vince,
I know it has only been a couple weeks since my below note, but I wanted to quickly circle back as a courtesy reminder with the service anniversary date being 5 weeks from today.

Have a good day
Ryan

From: Ryan Matthews
Sent: Wednesday, January 06, 2016 2:36 PM
To: vincent.traver@co.mcleod.mn.us
Subject: McLeod County | ZixCorp renewal

Hi Vince,
Allow me to introduce myself; I am on the Renewals Team at Zix. McLeod County's Zix services have a March 1 service anniversary date. Note you have 3 agreements with Zix and this will combine all services to 1 agreement.

Your current agreement is a 3-year, paid annual term. Several customers have requested a 5-year term to lock in a lower service price for a longer amount of time so I want to offer that to you as well. The renewal options are:

Option 1: 3-year agreement, paid annually, at $12,455/yr
Option 2: 5-year agreement, paid annually, at $11,985/yr

Please let me know which option you prefer and I will put together the Services Agreement.

Thanks for your time and business since 2010.

-Ryan

Ryan Matthews
Renewals
ZixCorp

Office: 214.370.2291
Cell: 214.507.4917
Fax: 214.370.2074

Personnel Committee

Tuesday, February 9, 2016

Lg Conf Room Room - North Complex

AGENDA

A. Discuss Summer Workers for Parks and Fairgrounds

Recommendation: Hire the following Summer Workers for Parks Department: 3 at 36 hours per week, 1at 20 hours per week and 1at 14 hours per week and 2 Summer Workers for Fairgrounds at 40 hours per week. These will be for approximately 12 weeks and the starting wage will be $9.00 per hour. Returning staff will receive a 2% plus $.20 increase.

Recommendation: Hire 14 hour (year round) Fairgrounds Worker due to resignation.

B. Discuss Summer Workers for Solid Waste

Recommendation: Hire 2 Summer Interns for Solid Waste (one for MRF and one for HHW). Starting wage is $9.25 per hour with returning staff receiving a 2% plus $.20 increase. These will be for approximately 12 weeks.

C. Discuss Office Support Aide (grade 9) position in Solid Waste

Recommendation: Hire full-time Office Support Aide (grade 9) at Solid Waste due to resignation.

D. Discuss Summer Workers for Highway

Recommendation: Hire the five Summer Workers for Highway. One for Engineering, 3 for Maintenance (2 for Road Crew and 1 for Signs) and one to assist GIS. Starting wage will be $10.25 per hour with returning staff receiving a 2% plus $.20 per hour increase. These will be for approximately 12 weeks.

Please note that the Committee Chairperson has responsibility to invite staff not copied on this Agenda and expected to attend the meeting.

CC: All Commissioners
All Department Heads
Mary Jo Wieseler
Pat Melvin

MEDICA®

Medica Choice Passport

SIBLEY/MCLEOD HEALTH INSURANCE PLAN HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

Administered by Medica Self-Insured

SIBLEY/MCLEOD COUNTY

MEDICA CHOICE PASSPORT 500-30-20%

SILVER

BPL #29438

GROUP #45192, 45193, 45799

JANUARY 1, 2016

MEDICA CUSTOMER SERVICE

Minneapolis/St. Paul Metro Area:
(952) 945-8000

Outside the Metro Area:
1-800-952-3455

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

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

هذه المعلومات إتصل بالرقم الموجود على ظهر بطاقة
اذا كنت تحتاج مساعدة مجانية في ترجمة هذه المعلومات
التعريف الطبية الخاصة لك Medica

Haddii aad doonayso in Af Soomaali laguugu tarjamadda macluumaadkani, oo lacag la'aan ah, Fadlan wac Lambarka ku qoran Kaarka Caafimaadka ee Medica dhabarkiisa.

Ako zelite besplatano tumacenje ovih informacija posovite broj na pozadini vase Medica kartice.

Yog koj xav tau kev pab txhais cov ntaub ntawv no dawb, hu rau tus xov tooj nyob nram qab koj daim Medica Khaj (card).

ຖ້າທ່ານຕ້ອງໃຫ້ຊ່ວຍແປພາສາ ຖືຂໍ້ມູນເຫຼົ່ານີ້ ຈົ່ງໂທຄວາມເລກ ທີ່ໃຫ້ໄວ້ຢູ່ຂ້າງຫຼັງ ເມດິກາ ຖືບັດ ການສຸຂພາບ7ງ່ຳການ ຂອງ Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

ប្រសិនបើអ្នកចង់បានការជួយបកប្រែដោយឥតគិតថ្លៃពីព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខទូរស័ព្ទ នៅខាងក្នុងកាតមេឌីកា Medica ។

Si usted desea ayuda gratuita para traducir esta información, llame al número de teléfono situado al reverso de su tarjeta de identificación de Medica.

Nếu quý vị muốn được giúp đỡ dịch tài liệu này miễn phí, xin gọi số ghi ở mặt sau thẻ Medica cua quý vị.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.

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Introduction

See **Definitions** at the end of this document for defined terms and phrases.

Sibley/McLeod County (sponsor) has established the Sibley/McLeod Health Insurance Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Sibley/McLeod County (plan administrator). This plan was originally established January 1, 1993. This restatement of the plan is effective January 1, 2016 unless specifically stated otherwise.

The plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code) and applicable Minnesota law, including but not limited to Section 471.617 of the Minnesota Statutes.

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

In this plan, the words you, your, and yourself refer to the covered person. The word sponsor refers to the organization through which you are eligible for coverage.

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

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

What you must do to be eligible for benefits

Each time you receive health services, you must:

1. Confirm with Customer Service that your provider is a network provider with Medica Choice Passport; and
2. Identify yourself as a covered person under the plan; and
3. Present your plan identification card. However, possession and use of a plan identification card does not necessarily guarantee coverage.

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

If you need language interpretation

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

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

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

Medica's nondiscrimination policy

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

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

Plan Overview

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

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this document. Please contact Customer Service to make such a request. **If this plan is translated into another language, this written English version governs all coverage decisions.**

General plan information

Plan Name

Sibley/McLeod Health Insurance Plan

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

Agent for Service of Legal Process

Sibley County Attorney

Sponsor IRS Employer Identification Number (EIN)

McLeod County 41-6005841

Sibley County 41-6005897

Plan Year

January 1 through December 31

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network; claims processing services; and complaint resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from the general assets of sponsor. You may be responsible for a portion of the cost of the coverage provided under this plan. The portion of the cost of coverage for which the enrollee is responsible may be paid on a pre-tax basis through a cafeteria plan of sponsor if such a plan is made available by sponsor.

Benefits

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

The benefits described in this plan document detail the medical benefits available under the plan. **Benefits & Coverage** describes the copayment, coinsurance, and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain things be done first (i.e., prior authorization be obtained). Not following these requirements may

impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **Exclusions**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right of Recovery**.

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

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

copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:

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

       For McLeod County: County Auditor, County Administrator, Technical Specialist III (Auditor); For Sibley County: Human Resource Coordinator, Payroll Coordinator, Auditor

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

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

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

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

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

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

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

Before You Access Care

This section provides information for you to consider before you access care.

Provider network

In-network benefits are available through the Medica Choice Passport provider network. To see which providers are in your plan's network, check the online search tool on mymedica.com or contact Customer Service.

If you access services from providers that are not contracted with Medica, out-of-network benefits will apply.

Referrals

If you obtain a referral for services that you'll receive from a non-network provider (or certain types of network providers), you must get prior authorization from Medica to get your best benefit.

Prior authorization

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

Prior authorization from the plan may be required before you receive certain services or supplies. Medica uses written procedures and criteria when reviewing your request for prior authorization to determine whether a particular service or supply is medically necessary and is a covered benefit. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com. Emergency services do not require prior authorization.

You, someone on your behalf, or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Customer Service to request prior authorization for a service or supply. You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to obtain prior authorization after you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

Obstetrics/gynecology services do not require prior authorization and will be covered at the in-network or out-of-network benefit level, as applicable.

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

- Reconstructive or restorative surgery;

- Certain drugs;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests; and
- Skilled nursing facility services.

Prior authorization is always required for:

- Organ and bone marrow transplant services; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

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

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

- 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); and
- Other applicable covered person information (i.e., plan identification number).

Medica will review your request and provide a response to you and your attending provider 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.

Both you and your provider will be informed of the decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or if it is concluded that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting.

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

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

Benefits

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

Under certain circumstances, Medica will authorize non-network provider services at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services aren't available from network providers.

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

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

- Discuss the expected billed charges with the non-network provider; and
- Contact Customer Service to verify the estimated amount Medica would pay for those services; and
- Calculate your likely out-of-pocket expenses; and
- If you wish to request that the plan authorize the non-network provider's services be covered at the in-network benefit level, follow the procedure to request prior authorization described in this section.

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

Scenario:

You choose to receive non-emergency inpatient care at a non-network hospital without an authorization from the plan. The out-of-network benefits apply to these services.

Assumptions:

1. You have previously satisfied your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. Medica's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally as a percentage coinsurance. In this scenario, we will use 40% coinsurance.
    b. In addition, the non-network provider will likely bill you for the amount that their charge exceeds what Medica reimburses them.
4. For this non-network hospital stay, you will be required to pay:
    - 40% coinsurance (40% of $15,000 = $6,000) and

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

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

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

The $15,000 amount you pay for billed charges in excess of the non-network provider reimbursement amount *will not* be applied toward the out-of-pocket maximum.

You will owe the provider this $15,000 amount regardless of whether you have previously reached your out-of-pocket maximum.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services received.

Claims

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

Continuity of care

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

In certain situations, you have a right to continuity of care:

1. If your current provider is terminated without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are new to Medica as a result of the sponsor changing its third party administrator 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.

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

Upon request, the plan will authorize continuity of care for up to 120 days as described in 1. and 2. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;

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

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

Upon request, Medica will authorize continuity of care for up to 120 days as described in 1. and 2. above in the following situations:

- if you are receiving culturally appropriate services and a network provider who has special expertise in the delivery of those culturally appropriate services is not available; or
- if you do not speak English and a network provider who can communicate with you, either directly or through an interpreter, is not available.

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

Benefits & Coverage

This section describes the services eligible for coverage and the expenses that are your responsibility to pay.

More detail about the services, procedures, drugs, and supplies that are covered can be found in **Covered Health Services**.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND LIFETIME MAXIMUM

Deductibles

Your plan may require that you meet a deductible amount before your claims for services are covered. The table below will indicate whether or not your plan has a deductible and where it will apply.

Out-of-pocket maximum

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

Please note: Charges for services that aren't covered and charges a non-network provider bills you that are in excess of the non-network provider reimbursement amount will not apply toward your out-of-pocket maximum. You will owe these amounts even if you had already reached your out-of-pocket maximum with amounts paid for other services.

Lifetime maximum amount

This is the maximum amount the sponsor will pay for covered out-of-network services that you receive while you are covered under this plan or any and all other benefit plans, programs, or arrangements offered by the sponsor. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential health benefits as defined in the Patient Protection and Affordable Care Act, including any amendments, regulations, rules, or other guidance issued with respect to the Act. Note, that if you reach a lifetime benefit maximum under one benefit package, option, plan, program, or arrangement offered by sponsor and either change packages, options, plans, programs, or arrangements offered by sponsor at open enrollment or under a special enrollment opportunity, the amounts paid for benefits under the first benefit package, option, plan, program, or arrangement will carry forward and count towards the applicable lifetime maximum benefit under the second benefit package, option, plan, program, or arrangement offered by sponsor. In other words, the lifetime maximum does not start anew.

Deductibles, Out-Of-Pocket Maximums, and Lifetime Maximum		
	Your cost if you visit an:	
	In-network provider	Out-of-network provider
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per covered person	$500	$1,000
Per family	$1,000	Per family deductible does not apply. Refer to the per covered person deductible above.
When covered persons in a family unit (an enrollee and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year, then all covered persons of the family unit are considered to have satisfied the applicable per covered person and per family deductible for that calendar year.		
Out-of-pocket maximum		
Per covered person	$2,000	$4,000
Per family	$4,000	$8,000
When covered persons in a family unit (an enrollee and his or her dependents) have together met the applicable per family out-of-pocket maximum for benefits received during the calendar year, then all covered persons of the family unit are considered to have met the applicable per covered person and per family out-of-pocket maximum for that calendar year.		
Lifetime maximum amount payable per covered person	Unlimited	$1,000,000. Applies to all benefits you receive under this plan or that you have received under another benefit package, option, plan, program, or arrangement offered by sponsor prior to participation in this plan.

Covered benefits and the amounts you pay

Important information

- Prior authorization from the plan may be required before you receive some services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See **Before You Access Care** for more information about the prior authorization process.
- For out-of-network benefits, in addition to the deductible and copayment or coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. These charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum. Please see **Benefits** in **Before You Access Care** for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.
- Any day, visit, or service limitation in this section includes days, visits, or services that you pay for in order to satisfy any part of your applicable deductible.

AMBULANCE

See **Covered Health Services** for more information about ambulance services.

Ambulance		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Emergency ambulance services or emergency ambulance transportation	20% coinsurance	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service – see eligibility criteria below	20% coinsurance	40% coinsurance

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

1. Transportation is from hospital to hospital, and
    a. Care for your condition isn't available at the hospital where you were first admitted; or
    b. If it is required by the plan; or
2. Transportation is from hospital to skilled nursing facility.

Not covered:

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

ANESTHESIA

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

Anesthesia		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Anesthesia services received in a non-inpatient setting	Nothing. The deductible does not apply.	30% coinsurance
2. Anesthesia services received during an inpatient stay	20% coinsurance	40% coinsurance

BEHAVIORAL HEALTH – MENTAL HEALTH

Prior authorization. For mental health prior authorization requirements, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Office visits, including evaluations, diagnostic, and treatment services	$25/visit-group; $30/visit-individual. The deductible does not apply.	30% coinsurance
2. Intensive outpatient programs	$30/day. The deductible does not apply.	30% coinsurance

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional. Examples of such therapy include applied behavioral analysis, intensive early intervention behavior therapy, and intensive behavioral intervention.	20% coinsurance	40% coinsurance
4. Inpatient services (including residential treatment services) **Note:** These services include inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children.		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending psychiatrist services	20% coinsurance	40% coinsurance
d. Partial program	20% coinsurance	40% coinsurance

Not covered:

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

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Prior authorization. For prior authorization requirements of in-network and out-of-network benefits, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Substance Abuse		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Office visits, including evaluations, diagnostic, and treatment services	$25/visit-group; $30/visit-individual. The deductible does not apply.	30% coinsurance
2. Intensive outpatient programs	$30/day. The deductible does not apply.	30% coinsurance
3. Opiate replacement therapy	20% coinsurance	40% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending physician services	20% coinsurance	40% coinsurance

Not covered:

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

7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

CLINICAL TRIALS

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

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND MEDICAL SUPPLIES

See **Covered Health Services** for more information about durable medical equipment, prosthetics, and medical supplies.

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Durable medical equipment and certain related supplies	20% coinsurance	40% coinsurance
2. Prosthetics:	20% coinsurance	40% coinsurance
a. External prosthetic devices that replace a limb or an external body part, limited to:		
i. Artificial arms, legs, feet, and hands;		
ii. Artificial eyes, ears, and noses;		
iii. Breast prostheses		
b. Scalp hair prostheses due to alopecia areata – limited to one prosthesis (i.e. wig) per covered person per calendar year		
c. Repair, replacement, or revision of prostheses made necessary by normal wear and use		
3. Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures	20% coinsurance. Coverage is limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	40% coinsurance. Coverage is limited to one hearing aid per ear every three years.
4. Breast pumps	Nothing. The deductible does not apply.	30% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
5. Medical supplies: a. Blood clotting factors b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and	20% coinsurance	40% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6. Eligible ostomy supplies	20% coinsurance	40% coinsurance
7. Insulin pumps and other eligible diabetic equipment and supplies	20% coinsurance	40% coinsurance

Not covered:

1. Durable medical equipment, supplies, prosthetics, appliances, and hearing aids not on the plan eligible list.
2. Charges in excess of the plan standard model of durable medical equipment, prosthetics, or hearing aids.
3. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, except when made necessary by normal wear and use.
4. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, due to loss, damage, or theft.
5. Duplicate durable medical equipment, prosthetics, and hearing aids, including repair, replacement, or revision of duplicate items.
6. Other disposable supplies and appliances, except as described in **Benefits & Coverage** or **Covered Health Services**.

EMERGENCY ROOM CARE

Emergency services from non-network providers will be covered as in-network benefits. If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-

network benefits until your attending physician agrees it is safe to transfer you to a network facility.

See **Covered Health Services** for more information about emergency room care.

Emergency Room Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Services provided in a hospital or facility-based emergency room	$75/visit. The deductible does not apply.	Covered as an in-network benefit.
2.	Services received from a physician during an emergency room visit	Nothing. The deductible does not apply.	Covered as an in-network benefit.

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices received in an office or outpatient hospital **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	20% coinsurance	40% coinsurance

Genetic Testing and Counseling		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically **Please note:** Genetic counseling for BRCA testing, if appropriate, is covered as a women's preventive health service.	$30/visit. The deductible does not apply.	30% coinsurance

HOME HEALTH CARE

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

See **Covered Health Services** for more information.

Home Health Care		
	Your cost if you use an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Skilled physical, speech, or occupational therapy when you are homebound	20% coinsurance	40% coinsurance

Home Health Care		
	Your cost if you use an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
c. Home infusion therapy Benefits covered under a. and b. above are limited to a combined maximum of 120 visits per calendar year for in-network and 60 visits per calendar year for out-of-network benefits. If you have Medica coverage and are also enrolled in the Medical Assistance Program, you may be eligible for additional intermittent skilled care.		
2. Services received in your home from a physician	20% coinsurance	40% coinsurance

Not covered:

1. Companion, homemaker, and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech, or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** and **Prescription Drugs** in **Benefits & Coverage**.

12. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.
14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

HOSPICE SERVICES

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

See **Covered Health Services** for more information.

Hospice Services		
	Your cost if you use an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Hospice services	Nothing. The deductible does not apply.	40% coinsurance

Not covered:

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

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

HOSPITAL SERVICES

Hospital and ambulatory surgical center services are covered. A physician must direct your care.

Hospital Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Outpatient hospital or ambulatory surgical center services	$30/visit. The deductible does not apply.	30% coinsurance
2. Services provided in a hospital observation room	$30/visit. The deductible does not apply.	30% coinsurance
3. Inpatient services For associated professional services, see **Physician Services** in **Benefits & Coverage**.	20% coinsurance	40% coinsurance

Not covered:

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.
2. Transfers and admissions to network hospitals solely at the convenience of the covered person.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY TREATMENT

Coverage for infertility treatment is limited to a maximum of $5,000 per covered person per calendar year for in-network and out-of-network benefits combined.

In-network benefits apply to infertility services received from a network provider.

Out-of-network benefits apply to infertility services received from a non-network provider.

See **Covered Health Services** for more information.

Infertility Treatment			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Office visits, including any services provided during such visits	20% coinsurance	40% coinsurance
2.	Outpatient services received at a hospital	20% coinsurance	40% coinsurance
3.	Inpatient services	20% coinsurance	40% coinsurance
4.	Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance

Not covered:

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage**.
2. In vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
5. Sperm banking.
6. Adoption.

7. Donor sperm.
8. Donor eggs.
9. Embryo and egg storage.

LAB AND PATHOLOGY

Lab and Pathology		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Lab and pathology services received in an office or other non-inpatient hospital setting	20% coinsurance	40% coinsurance
2. Lab and pathology services received during an inpatient hospital setting	20% coinsurance	40% coinsurance

MEDICAL-RELATED DENTAL SERVICES

Medical-related dental services are covered. Services must be received from a physician or dentist.

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a physician;	$30/visit. The deductible does not apply.	30% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Received during a dental procedure; and c. Provided to a covered person who is: i. a child under age five; ii. is severely disabled; or iii. has a condition and requires hospitalization or general anesthesia for dental care treatment		
2. For a dependent child, orthodontia, dental implants, and oral surgery treatment related to cleft lip and palate	20% coinsurance	40% coinsurance
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury	20% coinsurance	40% coinsurance

Medical-Related Dental Services		
Benefits	Your cost if you visit an: In-network provider, after deductible:	Out-of-network provider, after deductible:
b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.		
4. Oral surgery for: a. Partially or completely unerupted impacted teeth; b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth	20% coinsurance	40% coinsurance

Not covered:

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

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

PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES

Physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis are covered. A physician must direct your care in order for it to be eligible for coverage.

Coverage for services provided on an inpatient basis is as described under **Hospital Services** in **Benefits & Coverage**.

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

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Physical therapy services received outside of your home		
a. Habilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Rehabilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
2. Speech therapy services received outside of your home		
a. Habilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
b. Rehabilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
3. Occupational therapy services received outside of your home		
a. Habilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
b. Rehabilitative services	$30/visit. The deductible does not apply.	30% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).

5. Health clubs.
6. Voice training.
7. Group physical, speech, and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

PHYSICIAN SERVICES

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

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

See **Covered Health Services** for more information.

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits **Please note:** Some services received during an office visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an office visit copayment or coinsurance and outpatient surgical or imaging copayment or coinsurance apply.	$30/visit. The deductible does not apply.	30% coinsurance
2. Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit copayment or coinsurance and outpatient surgical copayment or coinsurance apply.	$30/visit. The deductible does not apply.	Covered as an in-network benefit.

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
3. Convenience care/retail health clinic visits	$15/visit. The deductible does not apply.	30% coinsurance
4. Virtual care	$15/visit. The deductible does not apply.	30% coinsurance
5. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton, and nerves of the body	$30/visit. The deductible does not apply.	30% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year.
6. Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
a. Received from a physician during an office visit, an urgent care visit, or an outpatient hospital or ambulatory surgical center visit	$30/visit. The deductible does not apply.	30% coinsurance
b. Received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
7. Non-surgical services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
8. Other outpatient hospital or ambulatory surgical center services received from a physician	$30/visit. The deductible does not apply.	30% coinsurance
9. Hearing exams	Nothing. The deductible does not apply.	No coverage

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
10. Routine annual eye exams	Nothing. The deductible does not apply.	No coverage
11. Allergy shots	Nothing. The deductible does not apply.	30% coinsurance
12. Diabetes self-management training and education, including medical nutrition therapy received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	$30/visit. The deductible does not apply.	30% coinsurance
13. Acupuncture. Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	$30/visit. The deductible does not apply.	30% coinsurance
14. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	$30/visit. The deductible does not apply.	30% coinsurance
15. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	$30/visit. The deductible does not apply.	30% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
16. Treatment to lighten or remove the coloration of a port wine stain	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

Not covered:

Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection.

PREGNANCY – MATERNITY CARE

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

See **Covered Health Services** for more information.

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Outpatient prenatal services	Nothing. The deductible does not apply.	30% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Inpatient hospital stay for labor and delivery services – mother	20% coinsurance	40% coinsurance
3. Physician services received during an inpatient stay for labor and delivery – mother	Nothing. The deductible does not apply.	30% coinsurance
4. Inpatient hospital stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance
5. Physician services received during an inpatient stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance
6. Labor and delivery services at a free-standing birth center		
a. Facility services for labor and delivery – mother	20% coinsurance	40% coinsurance
b. Physician services received for labor and delivery – mother	Nothing. The deductible does not apply.	30% coinsurance
c. Physician services – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
7. Postnatal services	Nothing. The deductible does not apply.	30% coinsurance
8. Home health care visit following delivery	Nothing. The deductible does not apply.	30% coinsurance

Not covered:

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

PRESCRIPTION DRUGS

Prescription drugs and supplies received from a pharmacy or a designated mail order pharmacy are covered. The coverage in the table below is your copayment or coinsurance for prescription and over-the-counter (OTC) drugs. You may experience an additional charge if you require a provider to administer self-administered drugs.

For more information about your prescription drug coverage, see **Covered Health Services**.

In this section, the phrase “covered drugs” is meant to include those prescription drugs, OTC drugs, and supplies found on the Preferred Drug List (PDL) that are prescribed by an authorized provider, unless those drugs and supplies are identified as not covered. The phrase “professionally administered drugs” means drugs that require intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase “self-administered drugs” means all other drugs. Specialty prescription drugs are defined in **Prescription Specialty Drugs** in **Benefits & Coverage**.

Prescription unit

Supply for one prescription unit from a pharmacy: 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply)

Supply for one prescription unit from a designated mail order pharmacy: 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply)

This is how the unit will be dispensed unless it is limited by the drug manufacturer’s packaging, dosing instructions, or Medica’s medication request guidelines. This includes quantity limits that

are indicated on the PDL. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

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

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
1. Outpatient covered drugs other than those described below or in **Prescription Specialty Drugs** in **Benefits & Coverage**		
Tier 1: $12 per prescription unit; or **Tier 2:** $50 per prescription unit; or **Tier 3:** $75 per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** $24 per prescription unit; or **Tier 2:** $100 per prescription unit; or **Tier 3:** $150 per prescription unit
2. Infertility covered drugs. Limited to a maximum benefit of $3,000 per calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** in **Benefits & Coverage** combined.		
Tier 1: $12 per prescription unit; or **Tier 2:** $50 per prescription unit; or **Tier 3:** $75 per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** $24 per prescription unit; or **Tier 2:** $100 per prescription unit; or **Tier 3:** $150 per prescription unit

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
3. Diabetic equipment and supplies, including blood glucose meters		
Tier 1: 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit	40% coinsurance per prescription unit	**Tier 1:** 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit
4. All FDA-approved drugs and other supplies (including women's contraceptives), and tobacco cessation products that are considered preventive health services		
Tier 1: Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit **Please note:** Tobacco cessation products are not available through a mail order pharmacy.

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (The plan will notify you before enforcement of this provision.)
2. Replacement of a drug due to loss, damage, or theft.
3. Appetite suppressants.
4. Tobacco cessation products or services dispensed through a mail order pharmacy.
5. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
6. Homeopathic medicine.

7. Specialty prescription drugs, except as described in **Prescription Specialty Drugs** in **Benefits & Coverage**.

PRESCRIPTION SPECIALTY DRUGS

Specialty prescription drugs received from a designated specialty pharmacy are covered.

Specialty prescription drugs include, but are not limited to, high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's Specialty Preferred Drug List (SPDL).

In this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs.

See **Covered Health Services** for additional important information about your specialty prescription drug coverage.

The table below describes your copayment or coinsurance for the specialty prescription drug. An additional copayment or coinsurance will apply for a provider's services if you require that they administer a self-administered drug.

Prescription unit

Supply for one prescription unit of a specialty prescription drug from a designated specialty pharmacy: 31-consecutive-day supply

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that are indicated on the SPDL.

Prescription Specialty Drugs		
	Benefits	**You pay**
1.	Specialty prescription drugs, other than those described below, received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Prescription Specialty Drugs	
Benefits	**You pay**
2. Specialty infertility prescription drugs received from a designated specialty pharmacy. Limited to a maximum benefit of $3,000 per calendar year for all infertility drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** combined.	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit
3. Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself to the designated specialty pharmacy as a covered person. (The plan will notify you before enforcement of this provision.)
2. Replacement of a specialty drug due to loss, damage, or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs, and OTC drugs, except as described in **Prescription Drugs** in **Benefits & Coverage**.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.

PREVENTIVE HEALTH CARE

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

If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance, or deductible, as

described elsewhere in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during a visit.

See **Covered Health Services** for more information.

Preventive Health Care			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	30% coinsurance
2.	Immunizations	Nothing. The deductible does not apply.	30% coinsurance
3.	Early disease detection services including physicals	Nothing. The deductible does not apply.	No coverage
4.	Routine screening procedures for cancer including, but not limited to, screening for ovarian cancer and prostate cancer	Nothing. The deductible does not apply.	30% coinsurance
5.	Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization	Nothing. The deductible does not apply.	30% coinsurance
6.	Other preventive health services	Nothing. The deductible does not apply.	30% coinsurance

RECONSTRUCTIVE AND RESTORATIVE SURGERY

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

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

Not covered:

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

Prescription Specialty Drugs in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.

SKILLED NURSING FACILITY

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

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

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

Skilled Nursing Facility		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per person per calendar year for in-network and out-of-network services combined	20% coinsurance	40% coinsurance
2. Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered	20% coinsurance	40% coinsurance
3. Services received from a physician during an inpatient stay in a skilled nursing facility	20% coinsurance	40% coinsurance

Not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.

4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech, and occupational therapy.
10. Long-term care.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

TRANSPLANT SERVICES

See **Covered Health Services** for more information.

Transplant Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Organ and bone marrow transplant services **Prior authorization is required for all transplant services.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Supplies and services related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by the plan under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial, or non-human organ implants or transplants and related services that would not be authorized by the plan under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**,

Prescription Specialty Drugs, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

WEIGHT LOSS SURGERY

Coverage for surgery for morbid obesity is provided. Services must be provided under the direction of a designated network physician and received at a designated network facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

See **Covered Health Services** for more information.

Weight Loss Surgery			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Weight loss surgery services	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Surgery for morbid obesity when performed by a network physician that is not a designated physician or received at a network facility that is not a designated facility.
2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by the plan.

6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

X-RAY AND OTHER IMAGING

X-Ray and Other Imaging			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	X-rays and other imaging services received in a non-inpatient setting	20% coinsurance	40% coinsurance
2.	MRI, CT, and PET CT scans	20% coinsurance	40% coinsurance
3.	X-rays and other imaging services received in an inpatient setting	20% coinsurance	40% coinsurance

Covered Health Services

This section describes services covered on this plan. The **Benefits & Coverage** section provides coverage specifics and what you would pay for each service.

Ambulance services

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, emergency health services at that hospital are covered.

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

Behavioral health – mental health

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

Outpatient mental disorder services include:

- Diagnostic evaluations and psychological testing.
- Psychotherapy and psychiatric services.
- Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Treatment for a minor, including family therapy.
- Treatment of serious or persistent disorders.
- Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Treatment of pathological gambling.
- Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional.

Inpatient mental disorder services include:

- Room and board.
- Attending psychiatric services.
- Hospital or facility-based professional services.
- Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and

supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.

- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Residential treatment services. These services include either:
  - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
  - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

The plan's designated mental health provider will arrange your in-network mental health benefits. If you require hospitalization, the plan's designated mental health provider will refer you to one of its hospital providers. (The plan and the designated mental health provider hospital networks are different.)

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

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

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

Behavioral health – substance abuse

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

Outpatient substance abuse services include:

- Diagnostic evaluations.
- Outpatient treatment.
- Intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

Inpatient substance abuse services include:

- Room and board.
- Attending physician services.
- Hospital or facility-based professional services.
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.
- Residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours (15 hours for children and adolescents) per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

The plan's designated substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, the plan's designated substance abuse provider will refer you to one of its hospital providers. (The plan and the designated substance abuse provider hospital networks are different.)

In-network benefits will apply to services, care or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

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

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

- Psychiatrist
- Psychologist

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

Durable medical equipment, prosthetics, and medical supplies

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

The plan periodically reviews and modifies the list of eligible durable medical equipment and certain related supplies. To request the most up-to-date list, call Customer Service at one of the telephone numbers listed inside the front cover.

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

In-network benefits apply when eligible equipment, services, and supplies are prescribed by a physician and received from a network provider. Hearing aids are covered as described in **Benefits & Coverage**, when prescribed by a network provider.

To request a list of durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.

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

Emergency room care

Emergency services from non-network providers will be covered as in-network benefits. If you receive scheduled or follow-up care after an emergency, services must be received from a network provider in order for you to receive in-network benefits.

Home health care

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

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

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

If you are a ventilator-dependent patient with communication needs, and you require private duty nurse or personal care assistant home care services in your home, the plan will cover up to 120 hours of communication training to assure adequate communication with hospital staff.

Hospice services

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

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

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

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

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

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

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

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

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

Infertility treatment

The diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child is covered. Coverage includes benefits for professional, hospital, and ambulatory surgical center services. Infertility treatment must be received from or under the direction of a physician. See **Benefits & Coverage – Prescription Drugs** for coverage of infertility drugs.

Medical-related dental services

Medically necessary outpatient dental services are covered. Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this plan. See **Benefits & Coverage** for specific services that are covered or excluded.

Newborn coverage

Your dependent newborn is covered from birth. The plan does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one of the telephone numbers listed inside the front cover for more information. If additional premium is required, the plan is entitled to all premiums due from the time of the infant's birth until the time you notify the plan of the birth. The plan may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see **Eligibility and Enrollment**.

Pregnancy – maternity care

Benefits for your pregnancy care include medical services for prenatal care, labor and delivery, postnatal care, and related complications.

<u>Prenatal care</u>

Prenatal services include:

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

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

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

- Conditions that have arisen concurrently with the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or skin rash.
- Miscarriage and ectopic pregnancy.

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this plan. Please refer to those sections for coverage information.

Labor and delivery

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

Postnatal care

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

One home health care visit is covered if it occurs within 4 days of discharge. If services are received after 4 days, please refer to **Home Health Care** in **Benefits & Coverage** for benefits.

Newborns' and Mothers' Health Protection Act of 1996

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

For benefits and the amounts you pay, see **Benefits & Coverage**. Each covered person's admission is separate from the admission of any other covered person. A separate deductible and copayment or coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery. **Please note:** We encourage you to enroll your newborn dependent under the plan within 30 days from the date of birth, date of placement for adoption, or date of adoption. Please refer to **Eligibility and Enrollment** for additional information.

Physician services

In-network benefits apply to:

- Professional services received from a network provider;
- Emergency services from non-network providers will be covered as in-network benefits.

Post-mastectomy coverage

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

Prescription drugs

Preferred Drug List (PDL)

Medica's PDL identifies whether a drug is classified by Medica as a Tier 1, Tier 2, or Tier 3 covered drug. In general, only drugs on Medica's PDL are eligible for coverage.

The PDL is grouped into the following tiers:

Tier 1 is your lowest copayment or coinsurance option. For the lowest out-of-pocket expense, you should consider a Tier 1 covered drug if you and your physician decide it is appropriate for your treatment.

Tier 2 is your higher copayment or coinsurance option. You may consider a Tier 2 covered drug to treat your condition if you and your physician decide it is appropriate.

Tier 3 is your highest copayment or coinsurance option. The covered drugs in Tier 3 are usually more costly.

If you have questions about Medica's PDL or whether a specific drug is covered (and/or the PDL tier in which the drug may be covered), or if you would like to request a copy of the PDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The PDL is also available when you sign in at mymedica.com.

Medica selects drugs for the PDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a drug on the PDL, and the tier to which a drug is assigned, are based on the drug's safety, efficacy, uniqueness, and cost.

Exceptions to the PDL

Exceptions to the PDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the PDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's PDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's PDL for safety reasons. Medica will grant an exception to the PDL if the patient's health care provider indicates to us that any of the following apply: (a) the PDL drug causes an adverse reaction in the patient; (b) the PDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to

the patient, unless the drug was removed from Medica's PDL for safety reasons. If you would like to request a copy of Medica's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain covered drugs require prior authorization, as indicated on the PDL. The network provider who prescribes the drug initiates prior authorization. The PDL is made available to providers, including pharmacies and the designated mail order pharmacies. You are responsible for paying the cost of drugs received if you do not meet the plan's authorization criteria.

Step therapy

The plan requires a step therapy process prior to coverage of certain drugs, as indicated on the PDL. Step therapy involves trying an alternative covered drug first (typically a Tier 1 drug) before moving to a Tier 2 or Tier 3 covered drug for treatment of the same medical condition. Applicable step therapy requirements must be met before Medica will cover Tier 2 or Tier 3 covered drugs.

Quantity limits

Certain covered drugs are assigned quantity limits, as indicated on the PDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Mail order pharmacy benefits

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

Diabetic equipment and supplies (excluding blood glucose meters) are available via mail order if received from a designated mail order pharmacy.

Preventive drugs and other services, as specifically defined in **Definitions**, are eligible for mail order coverage. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service. **Note: Tobacco cessation products are not available through mail order.**

Retail pharmacy benefits

Retail pharmacy benefits include, but are not limited to:

- Preventive drugs and other services, as specifically defined in **Definitions**. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service.
- Diabetic equipment and supplies, including blood glucose meters.
- Tobacco cessation products prescribed by a provider authorized to prescribe the product.
- Insulin pumps, as covered under **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.

See **Prescription Specialty Drugs** in **Benefits & Coverage** for growth hormone and other specialty prescription drug coverage information.

Prescription specialty drugs

Designated specialty pharmacies

A designated specialty pharmacy means a specialty pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to covered persons. For the current list of designated specialty pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com.

Specialty Preferred Drug List (SPDL)

Medica has a tiered SPDL that identifies specialty prescription drugs that are covered, unless they are otherwise listed as not covered in this plan. The SPDL also identifies whether a drug is classified by Medica as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on Medica's SPDL are eligible for benefits under this plan.

The applicable copayments and coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefits table in **Prescription Specialty Drugs** in **Benefits & Coverage**.

If you have questions about Medica's SPDL or whether a specific specialty prescription drug is covered (and/or the SPDL tier in which the drug may be covered), or if you would like to request a copy of the SPDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The SPDL is also available by signing in at mymedica.com.

Medica selects specialty drugs for the SPDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a specialty drug on the SPDL, and the tier to which a specialty drug is assigned, are based on the specialty drug's safety, efficacy, uniqueness, and cost.

Exceptions to the SPDL

Exceptions to the SPDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the SPDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's SPDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's SPDL for safety reasons. Medica will grant an exception to the SPDL if the patient's health care provider indicates to us that any of the following apply: (a) the SPDL drug causes an adverse reaction in the patient; (b) the SPDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's SPDL for safety reasons. If you would like to request a copy of Medica's SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain specialty prescription drugs require prior authorization from Medica. The network provider who prescribes the specialty drug initiates prior authorization. The SPDL is made available to providers, including designated specialty pharmacies. You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria.

Step therapy

The plan requires step therapy prior to coverage of specific specialty prescription drugs as indicated on the SPDL. Step therapy involves trying an alternative covered specialty prescription drug (typically a Tier 1 specialty prescription drug) before moving to certain other Tier 1 or Tier 2 specialty prescription drugs for treatment of the same medical condition. Applicable step therapy requirements must be met before the plan will cover certain Tier 1 or Tier 2 specialty prescription drugs.

Quantity limits

Certain specialty prescription drugs are assigned quantity limits as indicated on the SPDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Specialty prescription drugs are not subject to the deductible.

Transplant services – organ and bone marrow

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

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

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

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

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

In-network benefits apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a hospital that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities.

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

There is no coverage for out-of-network benefits.

Weight loss surgery

In-network benefits apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or designated facility is a network physician or hospital that has been designated by Medica to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

There is no coverage for out-of-network benefits.

Exclusions

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

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

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

16. Custodial care, unskilled nursing, or unskilled rehabilitation services.
17. Respite or rest care, except as otherwise covered in **Hospice Services** in **Benefits & Coverage**.
18. Travel, transportation, or living expenses.
19. Household equipment, fixtures, home modifications, and vehicle modifications.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies, and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and amyotrophic lateral sclerosis.
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability, or any similar law.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by the plan, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **Benefits & Coverage**.
30. Dental prostheses.
31. Any orthodontia, except as described in **Medical-Related Dental Services** in **Benefits & Coverage** for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
34. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
35. Exams, other evaluations, or other services received solely for the purpose of employment, insurance, or licensure.
36. Exams, other evaluations, or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities unless otherwise covered under this plan.
37. Non-medical self-care or self-help training.

38. Educational classes, programs, or seminars, including but not limited to childbirth classes, except as described in **Physician Services** in **Benefits & Coverage**.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this plan.
42. Orthognathic surgery for cosmetic purposes.
43. Services for sex transformation operations.
44. Sensory integration, including auditory integration training.
45. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician Services** in **Benefits & Coverage**.
46. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders for covered persons 18 years of age and older. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
47. Health care professional services for home labor and delivery.
48. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
49. Services solely for or related to the treatment of snoring.
50. Interpreter services, except as described in **Home Health Care** in **Benefits & Coverage**.
51. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
52. Services for private duty nursing, except as described in **Home Health Care** in **Benefits & Coverage**. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the covered person or the covered person's representative, and not under the direction of a physician.
53. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
54. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
55. Health clubs.
56. Long-term care.
57. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements, or publications.

58. Any charges for mailing, interest, and delivery, such as the cost for mailing medical records.

Role of Medica

The plan administrator has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica's responsibilities generally consist of determining the validity of claims pursuant to the terms of the plan and administering benefit payments under this plan and determining the resolution of complaints and appeals pursuant to the terms of **Complaints**. The service agreement between the plan administrator and Medica is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. Medica is a third party retained by the plan administrator. Medica is not a COBRA administrator. The plan offers Medica Choice Passport.

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

This section describes how providers are generally paid for health services. See **Definitions** at the end of this document for defined terms and phrases.

Network providers

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

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

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

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

Risk-sharing payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per covered person, or an amount

per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a covered person's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a covered person's health services, the network provider may keep some of the excess.

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

Withhold arrangements

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

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

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

Harmful Use of Medical Services

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

When this section applies

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

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

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

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

Medica will send you specific information about:

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

How to Submit a Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

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

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

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

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

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

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

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

Claims for services provided outside the United States

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

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

- Such other documentation as the plan may request.

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

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

Time limits

If you have a complaint or disagree with a decision by the plan, you may follow the complaint procedure outlined in **Complaints**.

Coordination of Benefits

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

Applicability

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

Definitions that apply to this section

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

   Each contract or other arrangement for coverage under a. or b. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
2. This plan is the part of the plan that provides benefits for health care expenses.
3. *Primary plan/secondary plan.* The **Order of benefit determination rules** state whether this plan is a primary plan or secondary plan as to another plan covering the person.

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

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

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

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

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

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

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

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

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

Order of benefit determination rules

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

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

   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.

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

   a. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, covered person, or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

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

   i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   ii. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in 2.b.i. immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

   i. First, the plan of the parent with custody of the child;

   ii. Then, the plan of the spouse of the parent with the custody of the child; and

   iii. Finally, the plan of the parent not having custody of the child.

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

d. *Joint custody*. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the **Order of benefit determination rules** outlined in 2.b.

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

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

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

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

Effect on the benefits of this plan

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

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

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

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

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

   When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under the plan, according to the out-of-network benefits described. Most out-of-network benefits are covered at 60 percent of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

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

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

Please note: See **Right of Recovery** for additional information.

Right of Recovery

This section describes this plan's right of recovery. This plan's rights may be subject to Minnesota and federal law. For information about the effect of applicable state and federal law on this plan's subrogation rights, contact an attorney.

See **Definitions** at the end of this document for defined terms and phrases.

1. This plan has a right of subrogation against any third party, individual, corporation, insurer, or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. This plan's right of subrogation shall be governed according to this section. This plan's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. This plan's subrogation interest is the reasonable cash value of any benefits received by you.
3. This plan's right to recover its subrogation interest may be subject to an obligation by the plan to pay a pro rata share of your disbursements, attorney fees, and costs you pay in obtaining your recovery.
4. By accepting coverage under the plan, you agree:
    a. To cooperate with the plan administrator, sponsor, or plan designee to help protect the plan's legal rights under this subrogation provision and to provide all information the plan may reasonably request to determine its rights under this provision.
    b. To provide prompt written notice to the plan administrator when you make a claim against a party for injuries.
    c. To provide prompt written notice of the plan's subrogation rights to any party against whom you assert a claim for injuries.
    d. To do nothing to decrease the plan's rights under this provision, either before or after receiving benefits.
    e. The plan may take action to preserve its legal rights. This includes bringing suit in your name.
    f. The plan may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative, or the legal representative(s) of your estate or next-of-kin.
    g. To hold in trust the proceeds of any settlement or judgment for the plan's benefit under this provision.

Eligibility and Enrollment

This section describes who can enroll and how to enroll.

Who can enroll

All qualified employees and dependents as defined in **Definitions** are eligible for coverage under this plan. In order for an eligible dependent to enroll in the plan, the qualified employee must also be enrolled.

How to enroll

Submit an application for coverage for the qualified employee and/or any dependents to the plan administrator:

1. During the initial enrollment period as described in this section under **Initial enrollment and effective date of coverage**; or
2. During the open enrollment period as described in this section under **Open enrollment and effective date of coverage**; or
3. During a special enrollment period as described in this section under **Special enrollment and effective date of coverage**; or
4. At any other time as a late enrollee as described in this section under **Late enrollment and effective date of coverage**.

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

Initial enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and/or any dependents to the plan administrator during the initial enrollment period, which will be communicated to the qualified employee by the plan administrator.

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

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

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the first of the month following 30 days (one month) of employment.

Open enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and any dependents to the plan administrator during the open enrollment period, which will be communicated to the qualified employee by the plan administrator. Open enrollment period means the period of time occurring toward the end of the calendar year during which qualified employees and eligible dependents who are not covered under the plan may elect to begin coverage effective the first day of the upcoming calendar year.

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

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

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified employees and dependents under certain circumstances. Qualified employees and dependents who are eligible to enroll during a special enrollment period may enroll in any medical benefit package or option available to similarly situated individuals who enroll when first eligible. **However, all other provisions of the plan, including but not limited to provisions setting a lifetime maximum on benefits, will apply to special enrollees.**

1. Loss of other coverage

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

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

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under creditable coverage other than Medicaid or a State Children's Health Insurance Plan at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment, and declined coverage for that reason.

    The qualified employee or dependent must present to the plan administrator either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated, and

request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

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

ii. Loss of eligibility includes:

- loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
- cessation of dependent status;
- incurring a claim that causes the qualified employee or dependent to meet or exceed the lifetime maximum limit on all benefits;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the qualified employee or dependent.

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

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

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent that has lost coverage and the qualified employee; dependents will not be enrolled without the qualified employee also being enrolled.

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

The qualified employee or dependent must present to the plan administrator evidence that the qualified employee or dependent has exhausted such COBRA or

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

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
- losing coverage as a result of the employer's failure to remit premiums on a timely basis; or
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

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

iii. In the case of the qualified employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee; dependents will not be enrolled without the qualified employee also being enrolled.

2. The dependent is a new spouse of the enrollee or qualified employee, provided that the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided that the qualified employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided that enrollment is requested in writing within 30 days of the enrollee or qualified employee acquiring the dependent and provided that the qualified employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption, or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the enrollee acquires the dependent child.

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

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the plan; and

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

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

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

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

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

7. When the qualified employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children's Health Insurance Plan. The qualified employee must request enrollment within 60 days after the date the employee or dependent is determined to be eligible for premium assistance.

   In the case of the qualified employee becoming eligible for premium assistance, this special enrollment period applies to the qualified employee and all of his or her dependents. In the case of a dependent becoming eligible for premium assistance, this special enrollment period applies to both that dependent and the qualified employee. Coverage is effective the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator.

Late enrollment and effective date of coverage

The plan allows enrollment as a late enrollee for qualified employees and eligible dependents enrolling outside of the initial enrollment period, the open enrollment period, or any special enrollment period described in this section.

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

Coverage will be effective the first day of the month following the date of the plan administrator's approval of the request for enrollment.

Medical Support Order

The plan is intended to comply with the requirements of applicable Minnesota law regarding medical support orders. This may result in the delay of a termination of coverage as described in **Ending Coverage**. Notwithstanding any provision of this plan to the contrary, this plan shall recognize support orders that address medical coverage for dependent children and former spouses in accordance with the requirements under Section 518A.41 of the Minnesota Statutes as determined by the plan administrator according to its policy relating to the plan established for the purpose of complying with these requirements.

Ending Coverage

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

When your coverage ends

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

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The end of the month for which the enrollee or covered person last paid any required contribution to the plan.
3. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. See **Eligibility and Enrollment** for information on eligibility.
4. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
5. The end of the month following the date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
6. The date specified by the plan administrator because a covered person permitted the use of his or her identification card by any unauthorized person or used another person's card or submitted fraudulent claims.
7. The end of the month in which a covered person enters active military duty for more than 31 days. Upon completion of active military duty, contact the plan administrator to discuss reinstatement of coverage.
8. The date specified by the plan administrator in written notice to a covered person that coverage ended due to the plan administrator's determination that the covered person committed fraud in applying for this coverage or for any of its benefits. Fraud includes, but is not limited to, intentionally providing the plan administrator with false material information such as:

    a. Information related to an enrollee's eligibility or another person's eligibility for coverage or status as a dependent; or

    b. Information related to an enrollee's health status or that of any dependent; or

    c. Intentional misrepresentation of the employer-employee relationship.

    Coverage will be retroactively terminated at the plan administrator's discretion to the original date of coverage or the date on which the fraudulent act took place. No continuation privilege will be extended.

Continuation

Required continuation coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under state law, federal law, or both. All aspects of continuation coverage administration are the responsibility of the plan administrator.

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

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

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

Your right to continue coverage under state law

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

1. **Minnesota state continuation coverage.**

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

2. **Notice of rights.**

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

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

Enrollee's loss

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

Enrollee's spouse's loss

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

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. Dissolution of marriage from the enrollee;
4. The enrollee's enrollment for benefits under Medicare.

Enrollee's child's loss

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

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. Termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. The enrollee's dissolution of marriage from the child's other parent;
4. The enrollee's enrollment for benefits under Medicare if the enrollee is the parent through whom the child receives coverage;
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

Election rights

When the plan administrator is notified that one of these events has happened, the enrollee and the enrollee's dependents will be notified of the right to continuation coverage.

Consistent with Minnesota law, the enrollee and dependents have 60 days to elect continuation coverage for reasons of termination of the enrollee's employment or the enrollee's enrollment for benefits under Medicare measured from the later of:

1. The date coverage would be lost because of one of the events described above; or
2. The date notice of election rights is received.

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

The enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. Under certain circumstances, the enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

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

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the sponsor of all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage.

Surviving dependents of a deceased enrollee have 90 days after notice of the requirement to pay continuation premiums to make the first payment.

Duration

Under the circumstances described above and for a certain period of time, Minnesota law requires that the enrollee and his or her dependents be allowed to maintain continuation coverage as follows:

1. For instances where coverage is lost due to the enrollee's termination of or layoff from employment, coverage may be continued until the earliest of:
    a. 18 months after the date of the termination of or layoff from employment;
    b. The date the enrollee becomes covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
    c. The date coverage would otherwise terminate under the plan.

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

    If a dissolution of marriage occurs during the period of time when the enrollee s spouse is continuing coverage due to the enrollee's termination of or layoff from employment, coverage of the enrollee's spouse may be continued until the earlier of:
    a. The date the former spouse becomes covered under another group health plan; or
    b. The date coverage would otherwise terminate under the plan.
5. If coverage is lost because of the enrollee's absence from work due to total disability, coverage of the enrollee and any dependents may be continued until the date coverage would otherwise terminate under the plan.
6. Upon the death of the enrollee, the coverage of a enrollee's spouse or dependent children may be continued until the earlier of:
    a. The date the surviving spouse and dependent children become covered under another group health plan; or
    b. The date coverage would have terminated under the plan had the enrollee lived.

Extension of benefits for total disability of the enrollee

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

Your right to continue coverage under federal law

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

COBRA continuation coverage

Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended as it applies to state governmental entities through the Public Health Service Act (PHSA), as amended. The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General COBRA information in this section. In addition, continuation of coverage requirements under Minnesota law shall be followed as described in this section.

USERRA continuation coverage

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

General COBRA information

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

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

Qualified beneficiary

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

1. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);
2. A covered spouse of a covered employee; or
3. A dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Enrollee's loss

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

Enrollee's spouse's loss

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

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. Divorce or legal separation from the enrollee; or
4. The enrollee's entitlement to (actual coverage under) Medicare.

Enrollee's child's loss

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

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. The enrollee's termination of employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. The enrollee's divorce or legal separation from the child's other parent;
4. The enrollee's entitlement to (actual coverage under) Medicare if the enrollee is the parent through whom the child receives coverage; or
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator of that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the plan administrator within 30 days of the determination.

Bankruptcy

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

Election rights

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

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

1. The date coverage would be lost because of one of the events described above, or
2. The date notice of election rights is received.

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

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

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

Type of coverage and cost

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

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

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

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the plan because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended if a second event (e.g., divorce, legal separation, or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's covered dependent who is determined to be disabled under the Social Security Act at the time of

the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period.

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

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

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

1. The enrollee's employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
4. The enrollee becomes entitled to (actually covered under) Medicare.

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

General USERRA information

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

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

Employee's loss

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

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and the

time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

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

Election rights

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

Type of coverage and cost

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

Duration of USERRA coverage

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

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

1. The employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;
4. The employee fails to return to work following the completion of his or her service in the uniformed services; or
5. The employee returns to work and is reinstated under the plan as an active employee.

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

COBRA and USERRA coverage are concurrent

If the employer is subject to both COBRA and USERRA, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

Other continuation coverage

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

Retiree coverage

Retiree coverage shall be provided in accordance with Section 471.61 of the Minnesota Statutes for a retiree and his or her dependents enrolled under the plan immediately preceding the enrollee's retirement. Sponsor may pay a portion of the premium for such coverage. Eligibility with respect to the availability of continuation coverage beyond the requirements of Minnesota Statutes Section 471.61 shall be determined by sponsor, pursuant to its Policy and Procedure. The retiree coverage may run concurrently with any available COBRA or state continuation coverage or the retiree coverage may be offered in lieu of the COBRA or state continuation coverage.

Surviving spouse

The surviving spouse (widow or widower) of a qualified employee or a retiree will remain eligible for coverage under this plan if:

1. Both the spouse and the qualified employee or retiree were covered persons under the plan at the time of the qualified employee's or retiree's death; and
2. The surviving spouse remains unmarried.

The sponsor may pay a portion of the premium for such coverage. Any available COBRA or state continuation coverage may run concurrently with surviving spouse coverage.

Leaves of absence

An enrollee on a leave of absence from employment with the sponsor and that is approved by the sponsor may be entitled to continuation coverage. The sponsor may pay a portion of the premium for such coverage. Eligibility, as it pertains to the availability of continuation coverage during a leave of absence, shall be determined by the sponsor, in accordance with its leave of absence policy. Any available COBRA or state continuation coverage may run concurrently with leave of absence coverage.

Insurability

A person does not have to demonstrate insurability to elect continuation coverage. At the end of the 18, 24, 29, or 36-month continuation period, as applicable, there is no opportunity to enroll in an individual conversion health plan.

Complaints

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

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in **First level of review**. You may also contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 539-1600 or 1-800-657-3602.

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

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

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

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

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

First level of review

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

Complaints that do not involve a medical necessity review by Medica:

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

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

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

2. For a written complaint, Medica will provide written notice of its first level of review decision to you within 30 days from initial receipt of your complaint.
3. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described below, must be exhausted before you have the right to submit a request for external review.

Complaints that involve a medical necessity review by Medica:

1. Your complaint must be made within one year following Medica's initial decision and may be made orally or in writing.
2. Medica will provide written notice of its first level of review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint.
3. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review, you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.
4. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level of review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.
5. If your complaint involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of the review process.

Second level of review

If you are not satisfied with Medica's first level of review decision, you may request a second level of review through either a written reconsideration or a hearing.

1. Your request can be oral or in writing. It must be provided to Medica within one year following the date of Medica's first level review decision. If your request is in writing, it must be sent to the address listed above in **First level of review**.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation, or other information provided by you, Medica staff, providers, and others is reviewed.

3. Medica will provide written notice of its second level of review decision to you within:

   a. 30 calendar days from receipt of written notice of your appeal for required second level of review; or

   b. 45 calendar days from receipt of written notice of your appeal for optional second level of review.

   For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. Generally, a second level of review is optional if the complaint requires a medical necessity review. Medica will inform you in writing whether the second level of review is optional or required.

External review

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

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

You must submit your written request for external review within six months from the date of Medica's decision. You must include a filing fee of $25 with your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. Contact the Commissioner of Commerce for more information about the external review process.

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

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

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

General Provisions

This section describes the general provisions of the plan.

Records

The sponsor, the plan administrator, Medica, and others to whom the sponsor has delegated duties and responsibilities under the plan shall keep accurate and detailed records of any matters pertaining to administration of the plan in compliance with applicable law.

Examination of a covered person

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

Clerical error and misstatements

Should a clerical error be found or should any misstatement of relevant facts pertaining to coverage under the plan be found, and should such error or misstatement affect the existence or amount of coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage. For example, you will not be eligible for coverage beyond the scheduled termination of coverage because of a failure to record the termination. On the other hand, you will not be deprived of coverage under the plan because of a clerical error.

Plan amendment and termination

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

Applicable law

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

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) imposes certain obligations on employers. This plan shall be administered in a manner consistent with USERRA.

Enrollee rights

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

Family and Medical Leave Act of 1993 (FMLA)

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

Reservation of discretion

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

Definitions

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

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

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

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

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

Coinsurance. The percentage amount you must pay to the provider for benefits received. Full coinsurance payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

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

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

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

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

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

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

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

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

Convenience care/retail health clinic. A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, which provides treatment of common illnesses and certain preventive health care services.

Copayment. The fixed dollar amount you must pay to the provider for benefits received. Full copayments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

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

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

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not medically necessary, or as determined by the plan.

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

Creditable coverage. Health coverage provided under one of the following plans:

1. A group health benefit plan, including a self-insured plan;
2. Health insurance coverage, whether through a group or individual contract;
3. Medicare;

4. Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines);
5. A state health benefit risk pool;
6. A military health plan or other coverage provided under United States Code, title 10, chapter 55;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. The Federal Employees Health Benefits Program or other similar coverage provided under federal law applicable to government organizations and employees;
9. A health benefit plan provided under Section 5(e) of the federal Peace Corps Act;
10. State Children's Health Insurance Program; or
11. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.

Coverages of the following types, including any combination of the following types, are *not* creditable coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance;
4. Workers' compensation insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Limited scope dental or vision coverage;
9. Coverage for long-term care, nursing home care, home health care, community-based care, or any combination of these;
10. Coverage only for a specified disease or illness;
11. Hospital indemnity or other fixed indemnity insurance; or
12. Medicare supplemental health insurance, benefits supplemental to military health care, and similar supplemental coverage if such benefits are provided under a separate policy or contract of insurance.

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

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

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

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

   For residents of a state other than Minnesota, the dependent limiting age may be higher if required by applicable state law.
3. The enrollee's or enrollee's spouse's disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. This dependent may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.
4. The enrollee's or enrollee's spouse's disabled dependent who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability and dependency at the time of the dependent's enrollment.

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

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

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

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

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

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

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

Enrollment date. The date of the qualified employee's or dependent's first day of coverage under the plan or, if earlier, the first day of the waiting period for the qualified employee's or dependent's enrollment.

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

Habilitative. Health care services are considered habilitative when they are provided to improve an impairment in physical function or speech due to congenital or developmental conditions, including autism spectrum disorders, that have impeded normal speech and motor development.

HIPAA privacy standards. Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended, and codified at 45 CFR Parts 160 and 164.

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

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

Investigative. As determined by the plan, 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. The plan will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

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

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

Late enrollee. A qualified employee or dependent who requests enrollment under the plan other than during:

1. The initial enrollment period set by the sponsor; or
2. The open enrollment period set by the sponsor; or
3. A special enrollment period as described in **Eligibility and Enrollment**.

In addition, a covered person who is a child entitled to receive coverage through a medical support order is not subject to any initial or open enrollment period restrictions.

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

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

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

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

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

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility, or pharmacy) that has entered into a written agreement to provide benefits to you. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically, without charge.

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

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

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

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

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

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

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

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

There are separate in-network and out-of-network out-of-pocket maximums for this plan. Once your out-of-pocket maximum for in-network and out-of-network is met, then other benefits in the same category are covered at 100 percent. For example, if your eligible out-of-pocket maximum for in-network benefits is met, all in-network benefits for the remainder of the calendar year are covered at 100 percent, but your out-of-network benefits will not be covered at 100 percent until that out-of-pocket maximum is met.

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

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

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

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

Placed for adoption. The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child. Eligibility for a child placed for adoption with the enrollee ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.

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

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

Plan administrator. Sibley/McLeod County.

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

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

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

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

Contact Customer Service for information regarding specific preventive health services, services that are rated A or B, and services that are included in guidelines supported by the Health Resources and Services Administration. For a list of preventive health services please sign in at medica.com.

Protected health information or PHI. With some exceptions, information that: (i) identifies or could reasonably be used to identify you; and (ii) relates to your physical or mental health or condition, the provision of your health care, or your payment for health care.

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

Qualified employee. An employee of sponsor. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the

sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

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

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your physician.

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

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

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

Retiree. A former employee who is an enrollee under the plan immediately preceding retirement and who, upon retirement:

1. Is receiving a disability benefit from a Minnesota public pension plan other than a volunteer firefighter plan or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan; or
2. Has met age and service requirements to receive an annuity from such a plan as described in 1. above.

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

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

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

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

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

Skilled care. Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for skilled care.

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

Sponsor. Sibley/McLeod County.

Total disability. Disability due to injury, sickness, or pregnancy that requires regular care and attendance of a physician, and in the opinion of the physician renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability and, after the first two years of the disability, renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted.

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

Virtual care. Professional evaluation and medical management services provided to patients through e-mail, telephone, or webcam. Virtual care includes interactive audiovisual telehealth services. Virtual care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results, or solely calling in a prescription to a pharmacy.

Waiting period. In accordance with applicable state and federal laws, the period of time, as determined by the sponsor's eligibility requirements, that must pass before a qualified employee and/or dependent becomes covered under the plan. However, if a qualified employee and/or dependent enrolls as a late enrollee or through either an open enrollment period or a special enrollment period as set forth herein in **Eligibility and Enrollment**, any period before such late, open, or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Signature

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

Sibley County

By: _____
(please print)

_____
(signature)

Its: _____

McLeod County

By: _____
(please print)

_____
(signature)

Its: _____

MEDICA®

Medica Choice Passport

SIBLEY/MCLEOD HEALTH INSURANCE PLAN HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

Administered by Medica Self-Insured

SIBLEY/MCLEOD COUNTY

MEDICA CHOICE PASSPORT 1000-40-30%

BRONZE

BPL #29439

GROUP #45957, 45958, 53441

JANUARY 1, 2016

MEDICA CUSTOMER SERVICE

Minneapolis/St. Paul Metro Area:
(952) 945-8000

Outside the Metro Area:
1-800-952-3455

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

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

هذه المعلومات إتصل بالرقم الموجود على ظهر بطاقة
اذا كنت تحتاج مساعدة مجانية في ترجمة هذه المعلومات
التعريف الطبية الخاصة لك Medica

Haddii aad doonayso in Af Soomaali laguugu tarjamadda macluumaadkani, oo lacag la'aan ah, Fadlan wac Lambarka ku qoran Kaarka Caafimaadka ee Medica dhabarkiisa.

Ako zelite besplatano tumacenje ovih informacija posovite broj na pozadini vase Medica kartice.

Yog koj xav tau kev pab txhais cov ntaub ntawv no dawb, hu rau tus xov tooj nyob nram qab koj daim Medica Khaj (card).

ຖ້າທ່ານຕ້ອງໃຫ້ຊ່ວຍແປພາສາ ຖືຂໍ້ມູນເຫຼົ່ານີ້ ຈົ່ງໂທຄວາມເລກ ທີ່ໃຫ້ໄວ້ຢູ່ຂ້າງຫຼັງ ແມເກົາ ຖືບັດ ກວດສຸຂະພາບ7ງ່ໍາກາຄເດ້ຂ Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

ប្រសិនបើអ្នកចង់បានការជួយបកប្រែដោយឥតគិតថ្លៃពីព័ត៌មានេះ សូមទូរស័ព្ទទៅលេខទូរស័ព្ទ នៅខាងក្នុងកាតមេឌីកា Medica ។

Si usted desea ayuda gratuita para traducir esta información, llame al número de teléfono situado al reverso de su tarjeta de identificación de Medica.

Nếu quý vị muốn được giúp đỡ dịch tài liệu này miễn phí, xin gọi số ghi ở mặt sau thẻ Medica cua quý vị.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.

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Introduction

See **Definitions** at the end of this document for defined terms and phrases.

Sibley/McLeod County (sponsor) has established the Sibley/McLeod Health Insurance Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Sibley/McLeod County (plan administrator). This plan was originally established January 1, 1993. This restatement of the plan is effective January 1, 2016 unless specifically stated otherwise.

The plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code) and applicable Minnesota law, including but not limited to Section 471.617 of the Minnesota Statutes.

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

In this plan, the words you, your, and yourself refer to the covered person. The word sponsor refers to the organization through which you are eligible for coverage.

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

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

What you must do to be eligible for benefits

Each time you receive health services, you must:

1. Confirm with Customer Service that your provider is a network provider with Medica Choice Passport; and
2. Identify yourself as a covered person under the plan; and
3. Present your plan identification card. However, possession and use of a plan identification card does not necessarily guarantee coverage.

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

If you need language interpretation

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

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

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

Medica's nondiscrimination policy

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

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

Plan Overview

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

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this document. Please contact Customer Service to make such a request. **If this plan is translated into another language, this written English version governs all coverage decisions.**

General plan information

Plan Name

Sibley/McLeod Health Insurance Plan

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

Agent for Service of Legal Process

Sibley County Attorney

Sponsor IRS Employer Identification Number (EIN)

McLeod County 41-6005841

Sibley County 41-6005897

Plan Year

January 1 through December 31

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network; claims processing services; and complaint resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from the general assets of sponsor. You may be responsible for a portion of the cost of the coverage provided under this plan. The portion of the cost of coverage for which the enrollee is responsible may be paid on a pre-tax basis through a cafeteria plan of sponsor if such a plan is made available by sponsor.

Benefits

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

The benefits described in this plan document detail the medical benefits available under the plan. **Benefits & Coverage** describes the copayment, coinsurance, and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain things be done first (i.e., prior authorization be obtained). Not following these requirements may

impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **Exclusions**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right of Recovery**.

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

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

copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:

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

       For McLeod County: County Auditor, County Administrator, Technical Specialist III (Auditor); For Sibley County: Human Resource Coordinator, Payroll Coordinator, Auditor

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

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

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

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

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

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

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

Before You Access Care

This section provides information for you to consider before you access care.

Provider network

In-network benefits are available through the Medica Choice Passport provider network. To see which providers are in your plan's network, check the online search tool on mymedica.com or contact Customer Service.

If you access services from providers that are not contracted with Medica, out-of-network benefits will apply.

Referrals

If you obtain a referral for services that you'll receive from a non-network provider (or certain types of network providers), you must get prior authorization from Medica to get your best benefit.

Prior authorization

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

Prior authorization from the plan may be required before you receive certain services or supplies. Medica uses written procedures and criteria when reviewing your request for prior authorization to determine whether a particular service or supply is medically necessary and is a covered benefit. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com. Emergency services do not require prior authorization.

You, someone on your behalf, or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Customer Service to request prior authorization for a service or supply. You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to obtain prior authorization after you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

Obstetrics/gynecology services do not require prior authorization and will be covered at the in-network or out-of-network benefit level, as applicable.

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

- Reconstructive or restorative surgery;

- Certain drugs;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests; and
- Skilled nursing facility services.

Prior authorization is always required for:

- Organ and bone marrow transplant services; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

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

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

- 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); and
- Other applicable covered person information (i.e., plan identification number).

Medica will review your request and provide a response to you and your attending provider 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.

Both you and your provider will be informed of the decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or if it is concluded that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting.

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

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

Benefits

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

Under certain circumstances, Medica will authorize non-network provider services at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services aren't available from network providers.

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

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

- Discuss the expected billed charges with the non-network provider; and
- Contact Customer Service to verify the estimated amount Medica would pay for those services; and
- Calculate your likely out-of-pocket expenses; and
- If you wish to request that the plan authorize the non-network provider's services be covered at the in-network benefit level, follow the procedure to request prior authorization described in this section.

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

Scenario:

You choose to receive non-emergency inpatient care at a non-network hospital without an authorization from the plan. The out-of-network benefits apply to these services.

Assumptions:

1. You have previously satisfied your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. Medica's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally as a percentage coinsurance. In this scenario, we will use 40% coinsurance.
    b. In addition, the non-network provider will likely bill you for the amount that their charge exceeds what Medica reimburses them.
4. For this non-network hospital stay, you will be required to pay:
    - 40% coinsurance (40% of $15,000 = $6,000) and

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

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

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

The $15,000 amount you pay for billed charges in excess of the non-network provider reimbursement amount *will not* be applied toward the out-of-pocket maximum.

You will owe the provider this $15,000 amount regardless of whether you have previously reached your out-of-pocket maximum.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services received.

Claims

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

Continuity of care

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

In certain situations, you have a right to continuity of care:

1. If your current provider is terminated without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are new to Medica as a result of the sponsor changing its third party administrator 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.

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

Upon request, the plan will authorize continuity of care for up to 120 days as described in 1. and 2. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;

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

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

Upon request, Medica will authorize continuity of care for up to 120 days as described in 1. and 2. above in the following situations:

- if you are receiving culturally appropriate services and a network provider who has special expertise in the delivery of those culturally appropriate services is not available; or
- if you do not speak English and a network provider who can communicate with you, either directly or through an interpreter, is not available.

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

Benefits & Coverage

This section describes the services eligible for coverage and the expenses that are your responsibility to pay.

More detail about the services, procedures, drugs, and supplies that are covered can be found in **Covered Health Services**.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND LIFETIME MAXIMUM

Deductibles

Your plan may require that you meet a deductible amount before your claims for services are covered. The table below will indicate whether or not your plan has a deductible and where it will apply.

Out-of-pocket maximum

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

Please note: Charges for services that aren't covered and charges a non-network provider bills you that are in excess of the non-network provider reimbursement amount will not apply toward your out-of-pocket maximum. You will owe these amounts even if you had already reached your out-of-pocket maximum with amounts paid for other services.

Lifetime maximum amount

This is the maximum amount the sponsor will pay for covered out-of-network services that you receive while you are covered under this plan or any and all other benefit plans, programs, or arrangements offered by the sponsor. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential health benefits as defined in the Patient Protection and Affordable Care Act, including any amendments, regulations, rules, or other guidance issued with respect to the Act. Note, that if you reach a lifetime benefit maximum under one benefit package, option, plan, program, or arrangement offered by sponsor and either change packages, options, plans, programs, or arrangements offered by sponsor at open enrollment or under a special enrollment opportunity, the amounts paid for benefits under the first benefit package, option, plan, program, or arrangement will carry forward and count towards the applicable lifetime maximum benefit under the second benefit package, option, plan, program, or arrangement offered by sponsor. In other words, the lifetime maximum does not start anew.

Deductibles, Out-Of-Pocket Maximums, and Lifetime Maximum		
	Your cost if you visit an:	
	In-network provider	Out-of-network provider
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per covered person	$1,000	$2,000
Per family	$2,000	Per family deductible does not apply. Refer to the per covered person deductible above.
When covered persons in a family unit (an enrollee and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year, then all covered persons of the family unit are considered to have satisfied the applicable per covered person and per family deductible for that calendar year.		
Out-of-pocket maximum		
Per covered person	$3,500	$5,500
Per family	$7,000	$10,000
When covered persons in a family unit (an enrollee and his or her dependents) have together met the applicable per family out-of-pocket maximum for benefits received during the calendar year, then all covered persons of the family unit are considered to have met the applicable per covered person and per family out-of-pocket maximum for that calendar year.		
Lifetime maximum amount payable per covered person	Unlimited	$1,000,000. Applies to all benefits you receive under this plan or that you have received under another benefit package, option, plan, program, or arrangement offered by sponsor prior to participation in this plan.

Covered benefits and the amounts you pay

Important information

- Prior authorization from the plan may be required before you receive some services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See **Before You Access Care** for more information about the prior authorization process.
- For out-of-network benefits, in addition to the deductible and copayment or coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. These charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum. Please see **Benefits** in **Before You Access Care** for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.
- Any day, visit, or service limitation in this section includes days, visits, or services that you pay for in order to satisfy any part of your applicable deductible.

AMBULANCE

See **Covered Health Services** for more information about ambulance services.

Ambulance		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Emergency ambulance services or emergency ambulance transportation	30% coinsurance	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service – see eligibility criteria below	30% coinsurance	50% coinsurance

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

1. Transportation is from hospital to hospital, and
    a. Care for your condition isn't available at the hospital where you were first admitted; or
    b. If it is required by the plan; or
2. Transportation is from hospital to skilled nursing facility.

Not covered:

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

ANESTHESIA

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

Anesthesia			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Anesthesia services received in a non-inpatient setting	Nothing. The deductible does not apply.	50% coinsurance
2.	Anesthesia services received during an inpatient stay	30% coinsurance	50% coinsurance

BEHAVIORAL HEALTH – MENTAL HEALTH

Prior authorization. For mental health prior authorization requirements, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Mental Health			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Office visits, including evaluations, diagnostic, and treatment services	$35/visit-group; $40/visit-individual. The deductible does not apply.	50% coinsurance
2.	Intensive outpatient programs	$40/day. The deductible does not apply.	50% coinsurance

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional. Examples of such therapy include applied behavioral analysis, intensive early intervention behavior therapy, and intensive behavioral intervention.	30% coinsurance	50% coinsurance
4. Inpatient services (including residential treatment services) **Note:** These services include inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children.		
a. Room and board	30% coinsurance	50% coinsurance
b. Hospital or facility-based professional services	30% coinsurance	50% coinsurance
c. Attending psychiatrist services	30% coinsurance	50% coinsurance
d. Partial program	30% coinsurance	50% coinsurance

Not covered:

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

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Prior authorization. For prior authorization requirements of in-network and out-of-network benefits, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Substance Abuse		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Office visits, including evaluations, diagnostic, and treatment services	$35/visit-group; $40/visit-individual. The deductible does not apply.	50% coinsurance
2. Intensive outpatient programs	$40/day. The deductible does not apply.	50% coinsurance
3. Opiate replacement therapy	30% coinsurance	50% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	30% coinsurance	50% coinsurance
b. Hospital or facility-based professional services	30% coinsurance	50% coinsurance
c. Attending physician services	30% coinsurance	50% coinsurance

Not covered:

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

7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

CLINICAL TRIALS

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

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND MEDICAL SUPPLIES

See **Covered Health Services** for more information about durable medical equipment, prosthetics, and medical supplies.

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Durable medical equipment and certain related supplies	30% coinsurance	50% coinsurance
2. Prosthetics:	30% coinsurance	50% coinsurance
a. External prosthetic devices that replace a limb or an external body part, limited to:		
i. Artificial arms, legs, feet, and hands;		
ii. Artificial eyes, ears, and noses;		
iii. Breast prostheses		
b. Scalp hair prostheses due to alopecia areata – limited to one prosthesis (i.e. wig) per covered person per calendar year		
c. Repair, replacement, or revision of prostheses made necessary by normal wear and use		
3. Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures	30% coinsurance. Coverage is limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	50% coinsurance. Coverage is limited to one hearing aid per ear every three years.
4. Breast pumps	Nothing. The deductible does not apply.	50% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
5. Medical supplies: a. Blood clotting factors b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and	30% coinsurance	50% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6. Eligible ostomy supplies	30% coinsurance	50% coinsurance
7. Insulin pumps and other eligible diabetic equipment and supplies	30% coinsurance	50% coinsurance

Not covered:

1. Durable medical equipment, supplies, prosthetics, appliances, and hearing aids not on the plan eligible list.
2. Charges in excess of the plan standard model of durable medical equipment, prosthetics, or hearing aids.
3. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, except when made necessary by normal wear and use.
4. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, due to loss, damage, or theft.
5. Duplicate durable medical equipment, prosthetics, and hearing aids, including repair, replacement, or revision of duplicate items.
6. Other disposable supplies and appliances, except as described in **Benefits & Coverage** or **Covered Health Services**.

EMERGENCY ROOM CARE

Emergency services from non-network providers will be covered as in-network benefits. If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-

network benefits until your attending physician agrees it is safe to transfer you to a network facility.

See **Covered Health Services** for more information about emergency room care.

Emergency Room Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Services provided in a hospital or facility-based emergency room	$95/visit. The deductible does not apply.	Covered as an in-network benefit.
2.	Services received from a physician during an emergency room visit	Nothing. The deductible does not apply.	Covered as an in-network benefit.

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices received in an office or outpatient hospital **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	30% coinsurance	50% coinsurance

Genetic Testing and Counseling		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically **Please note:** Genetic counseling for BRCA testing, if appropriate, is covered as a women's preventive health service.	$40/visit. The deductible does not apply.	50% coinsurance

HOME HEALTH CARE

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

See **Covered Health Services** for more information.

Home Health Care		
	Your cost if you use an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Skilled physical, speech, or occupational therapy when you are homebound	30% coinsurance	50% coinsurance

Home Health Care		
Benefits	Your cost if you use an: In-network provider, after deductible:	Out-of-network provider, after deductible:
c. Home infusion therapy Benefits covered under a. and b. above are limited to a combined maximum of 120 visits per calendar year for in-network and 60 visits per calendar year for out-of-network benefits. If you have Medica coverage and are also enrolled in the Medical Assistance Program, you may be eligible for additional intermittent skilled care.		
2. Services received in your home from a physician	30% coinsurance	50% coinsurance

Not covered:

1. Companion, homemaker, and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech, or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** and **Prescription Drugs** in **Benefits & Coverage**.

12. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.
14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

HOSPICE SERVICES

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

See **Covered Health Services** for more information.

Hospice Services		
	Your cost if you use an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Hospice services	Nothing. The deductible does not apply.	50% coinsurance

Not covered:

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

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

HOSPITAL SERVICES

Hospital and ambulatory surgical center services are covered. A physician must direct your care.

Hospital Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Outpatient hospital or ambulatory surgical center services	$40/visit. The deductible does not apply.	50% coinsurance
2. Services provided in a hospital observation room	$40/visit. The deductible does not apply.	50% coinsurance
3. Inpatient services For associated professional services, see **Physician Services** in **Benefits & Coverage**.	30% coinsurance	50% coinsurance

Not covered:

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.
2. Transfers and admissions to network hospitals solely at the convenience of the covered person.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY TREATMENT

Coverage for infertility treatment is limited to a maximum of $5,000 per covered person per calendar year for in-network and out-of-network benefits combined.

In-network benefits apply to infertility services received from a network provider.

Out-of-network benefits apply to infertility services received from a non-network provider.

See **Covered Health Services** for more information.

Infertility Treatment			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Office visits, including any services provided during such visits	30% coinsurance	50% coinsurance
2.	Outpatient services received at a hospital	30% coinsurance	50% coinsurance
3.	Inpatient services	30% coinsurance	50% coinsurance
4.	Services received from a physician during an inpatient stay	30% coinsurance	50% coinsurance

Not covered:

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage**.
2. In vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
5. Sperm banking.
6. Adoption.

7. Donor sperm.
8. Donor eggs.
9. Embryo and egg storage.

LAB AND PATHOLOGY

Lab and Pathology		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Lab and pathology services received in an office or other non-inpatient hospital setting	30% coinsurance	50% coinsurance
2. Lab and pathology services received during an inpatient hospital setting	30% coinsurance	50% coinsurance

MEDICAL-RELATED DENTAL SERVICES

Medical-related dental services are covered. Services must be received from a physician or dentist.

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a physician;	$40/visit. The deductible does not apply.	50% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Received during a dental procedure; and c. Provided to a covered person who is: i. a child under age five; ii. is severely disabled; or iii. has a condition and requires hospitalization or general anesthesia for dental care treatment		
2. For a dependent child, orthodontia, dental implants, and oral surgery treatment related to cleft lip and palate	30% coinsurance	50% coinsurance
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury	30% coinsurance	50% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.		
4. Oral surgery for:	30% coinsurance	50% coinsurance
a. Partially or completely unerupted impacted teeth;		
b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or		
c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth		

Not covered:

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

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

PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES

Physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis are covered. A physician must direct your care in order for it to be eligible for coverage.

Coverage for services provided on an inpatient basis is as described under **Hospital Services** in **Benefits & Coverage**.

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

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Physical therapy services received outside of your home		
a. Habilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Rehabilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
2. Speech therapy services received outside of your home		
a. Habilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
b. Rehabilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
3. Occupational therapy services received outside of your home		
a. Habilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
b. Rehabilitative services	$40/visit. The deductible does not apply.	50% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).

5. Health clubs.
6. Voice training.
7. Group physical, speech, and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

PHYSICIAN SERVICES

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

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

See **Covered Health Services** for more information.

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits **Please note:** Some services received during an office visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an office visit copayment or coinsurance and outpatient surgical or imaging copayment or coinsurance apply.	$40/visit. The deductible does not apply.	50% coinsurance
2. Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit copayment or coinsurance and outpatient surgical copayment or coinsurance apply.	$40/visit. The deductible does not apply.	Covered as an in-network benefit.

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
3. Convenience care/retail health clinic visits	$25/visit. The deductible does not apply.	50% coinsurance
4. Virtual care	$25/visit. The deductible does not apply.	50% coinsurance
5. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton, and nerves of the body	$40/visit. The deductible does not apply.	50% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year.
6. Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
a. Received from a physician during an office visit, an urgent care visit, or an outpatient hospital or ambulatory surgical center visit	$40/visit. The deductible does not apply.	50% coinsurance
b. Received from a physician during an inpatient stay	30% coinsurance	50% coinsurance
7. Non-surgical services received from a physician during an inpatient stay	30% coinsurance	50% coinsurance
8. Other outpatient hospital or ambulatory surgical center services received from a physician	$40/visit. The deductible does not apply.	50% coinsurance
9. Hearing exams	Nothing. The deductible does not apply.	No coverage

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
10. Routine annual eye exams	Nothing. The deductible does not apply.	No coverage
11. Allergy shots	Nothing. The deductible does not apply.	50% coinsurance
12. Diabetes self-management training and education, including medical nutrition therapy received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	$40/visit. The deductible does not apply.	50% coinsurance
13. Acupuncture. Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	$40/visit. The deductible does not apply.	50% coinsurance
14. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	$40/visit. The deductible does not apply.	50% coinsurance
15. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	$40/visit. The deductible does not apply.	50% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
16. Treatment to lighten or remove the coloration of a port wine stain	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

Not covered:

Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection.

PREGNANCY – MATERNITY CARE

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

See **Covered Health Services** for more information.

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Outpatient prenatal services	Nothing. The deductible does not apply.	50% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Inpatient hospital stay for labor and delivery services – mother	30% coinsurance	50% coinsurance
3. Physician services received during an inpatient stay for labor and delivery – mother	Nothing. The deductible does not apply.	50% coinsurance
4. Inpatient hospital stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	30% coinsurance	50% coinsurance
5. Physician services received during an inpatient stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	30% coinsurance	50% coinsurance
6. Labor and delivery services at a free-standing birth center		
a. Facility services for labor and delivery – mother	30% coinsurance	50% coinsurance
b. Physician services received for labor and delivery – mother	Nothing. The deductible does not apply.	50% coinsurance
c. Physician services – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	30% coinsurance	50% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
7. Postnatal services	Nothing. The deductible does not apply.	50% coinsurance
8. Home health care visit following delivery	Nothing. The deductible does not apply.	50% coinsurance

Not covered:

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

PRESCRIPTION DRUGS

Prescription drugs and supplies received from a pharmacy or a designated mail order pharmacy are covered. The coverage in the table below is your copayment or coinsurance for prescription and over-the-counter (OTC) drugs. You may experience an additional charge if you require a provider to administer self-administered drugs.

For more information about your prescription drug coverage, see **Covered Health Services**.

In this section, the phrase "covered drugs" is meant to include those prescription drugs, OTC drugs, and supplies found on the Preferred Drug List (PDL) that are prescribed by an authorized provider, unless those drugs and supplies are identified as not covered. The phrase "professionally administered drugs" means drugs that require intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs. Specialty prescription drugs are defined in **Prescription Specialty Drugs** in **Benefits & Coverage**.

Prescription unit

Supply for one prescription unit from a pharmacy: 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply)

Supply for one prescription unit from a designated mail order pharmacy: 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply)

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that

are indicated on the PDL. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

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

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
1. Outpatient covered drugs other than those described below or in **Prescription Specialty Drugs** in **Benefits & Coverage**		
Tier 1: $12 per prescription unit; or **Tier 2:** $50 per prescription unit; or **Tier 3:** $75 per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** $24 per prescription unit; or **Tier 2:** $100 per prescription unit; or **Tier 3:** $150 per prescription unit
2. Infertility covered drugs. Limited to a maximum benefit of $3,000 per calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** in **Benefits & Coverage** combined.		
Tier 1: $12 per prescription unit; or **Tier 2:** $50 per prescription unit; or **Tier 3:** $75 per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** $24 per prescription unit; or **Tier 2:** $100 per prescription unit; or **Tier 3:** $150 per prescription unit

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
3. Diabetic equipment and supplies, including blood glucose meters		
Tier 1: 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit	40% coinsurance per prescription unit	**Tier 1:** 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit
4. All FDA-approved drugs and other supplies (including women's contraceptives), and tobacco cessation products that are considered preventive health services		
Tier 1: Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit	$75 or 40% coinsurance (whichever is greater) per prescription unit	**Tier 1:** Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit **Please note:** Tobacco cessation products are not available through a mail order pharmacy.

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (The plan will notify you before enforcement of this provision.)
2. Replacement of a drug due to loss, damage, or theft.
3. Appetite suppressants.
4. Tobacco cessation products or services dispensed through a mail order pharmacy.
5. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
6. Homeopathic medicine.

7. Specialty prescription drugs, except as described in **Prescription Specialty Drugs** in **Benefits & Coverage**.

PRESCRIPTION SPECIALTY DRUGS

Specialty prescription drugs received from a designated specialty pharmacy are covered.

Specialty prescription drugs include, but are not limited to, high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's Specialty Preferred Drug List (SPDL).

In this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs.

See **Covered Health Services** for additional important information about your specialty prescription drug coverage.

The table below describes your copayment or coinsurance for the specialty prescription drug. An additional copayment or coinsurance will apply for a provider's services if you require that they administer a self-administered drug.

Prescription unit

Supply for one prescription unit of a specialty prescription drug from a designated specialty pharmacy: 31-consecutive-day supply

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that are indicated on the SPDL.

Prescription Specialty Drugs		
	Benefits	**You pay**
1.	Specialty prescription drugs, other than those described below, received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Prescription Specialty Drugs	
Benefits	**You pay**
2. Specialty infertility prescription drugs received from a designated specialty pharmacy. Limited to a maximum benefit of $3,000 per calendar year for all infertility drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** combined.	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit
3. Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself to the designated specialty pharmacy as a covered person. (The plan will notify you before enforcement of this provision.)
2. Replacement of a specialty drug due to loss, damage, or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs, and OTC drugs, except as described in **Prescription Drugs** in **Benefits & Coverage**.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.

PREVENTIVE HEALTH CARE

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

If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance, or deductible, as

described elsewhere in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during a visit.

See **Covered Health Services** for more information.

Preventive Health Care			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	50% coinsurance
2.	Immunizations	Nothing. The deductible does not apply.	50% coinsurance
3.	Early disease detection services including physicals	Nothing. The deductible does not apply.	No coverage
4.	Routine screening procedures for cancer including, but not limited to, screening for ovarian cancer and prostate cancer	Nothing. The deductible does not apply.	50% coinsurance
5.	Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization	Nothing. The deductible does not apply.	50% coinsurance
6.	Other preventive health services	Nothing. The deductible does not apply.	50% coinsurance

RECONSTRUCTIVE AND RESTORATIVE SURGERY

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

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

Not covered:

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

Prescription Specialty Drugs in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.

SKILLED NURSING FACILITY

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

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

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

Skilled Nursing Facility		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per person per calendar year for in-network and out-of-network services combined	30% coinsurance	50% coinsurance
2. Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered	30% coinsurance	50% coinsurance
3. Services received from a physician during an inpatient stay in a skilled nursing facility	30% coinsurance	50% coinsurance

Not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.

4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech, and occupational therapy.
10. Long-term care.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

TRANSPLANT SERVICES

See **Covered Health Services** for more information.

Transplant Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Organ and bone marrow transplant services **Prior authorization is required for all transplant services.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Supplies and services related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by the plan under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial, or non-human organ implants or transplants and related services that would not be authorized by the plan under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**,

Prescription Specialty Drugs, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

WEIGHT LOSS SURGERY

Coverage for surgery for morbid obesity is provided. Services must be provided under the direction of a designated network physician and received at a designated network facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

See **Covered Health Services** for more information.

Weight Loss Surgery			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Weight loss surgery services	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Surgery for morbid obesity when performed by a network physician that is not a designated physician or received at a network facility that is not a designated facility.
2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by the plan.

6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

X-RAY AND OTHER IMAGING

X-Ray and Other Imaging			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	X-rays and other imaging services received in a non-inpatient setting	30% coinsurance	50% coinsurance
2.	MRI, CT, and PET CT scans	30% coinsurance	50% coinsurance
3.	X-rays and other imaging services received in an inpatient setting	30% coinsurance	50% coinsurance

Covered Health Services

This section describes services covered on this plan. The **Benefits & Coverage** section provides coverage specifics and what you would pay for each service.

Ambulance services

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, emergency health services at that hospital are covered.

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

Behavioral health – mental health

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

Outpatient mental disorder services include:

- Diagnostic evaluations and psychological testing.
- Psychotherapy and psychiatric services.
- Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Treatment for a minor, including family therapy.
- Treatment of serious or persistent disorders.
- Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Treatment of pathological gambling.
- Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional.

Inpatient mental disorder services include:

- Room and board.
- Attending psychiatric services.
- Hospital or facility-based professional services.
- Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and

supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.

- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Residential treatment services. These services include either:
  - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
  - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

The plan's designated mental health provider will arrange your in-network mental health benefits. If you require hospitalization, the plan's designated mental health provider will refer you to one of its hospital providers. (The plan and the designated mental health provider hospital networks are different.)

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

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

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

Behavioral health – substance abuse

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

Outpatient substance abuse services include:

- Diagnostic evaluations.
- Outpatient treatment.
- Intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

Inpatient substance abuse services include:

- Room and board.
- Attending physician services.
- Hospital or facility-based professional services.
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.
- Residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours (15 hours for children and adolescents) per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

The plan's designated substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, the plan's designated substance abuse provider will refer you to one of its hospital providers. (The plan and the designated substance abuse provider hospital networks are different.)

In-network benefits will apply to services, care or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

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

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

- Psychiatrist
- Psychologist

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

Durable medical equipment, prosthetics, and medical supplies

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

The plan periodically reviews and modifies the list of eligible durable medical equipment and certain related supplies. To request the most up-to-date list, call Customer Service at one of the telephone numbers listed inside the front cover.

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

In-network benefits apply when eligible equipment, services, and supplies are prescribed by a physician and received from a network provider. Hearing aids are covered as described in **Benefits & Coverage**, when prescribed by a network provider.

To request a list of durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.

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

Emergency room care

Emergency services from non-network providers will be covered as in-network benefits. If you receive scheduled or follow-up care after an emergency, services must be received from a network provider in order for you to receive in-network benefits.

Home health care

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

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

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

If you are a ventilator-dependent patient with communication needs, and you require private duty nurse or personal care assistant home care services in your home, the plan will cover up to 120 hours of communication training to assure adequate communication with hospital staff.

Hospice services

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

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

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

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

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

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

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

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

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

Infertility treatment

The diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child is covered. Coverage includes benefits for professional, hospital, and ambulatory surgical center services. Infertility treatment must be received from or under the direction of a physician. See **Benefits & Coverage – Prescription Drugs** for coverage of infertility drugs.

Medical-related dental services

Medically necessary outpatient dental services are covered. Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this plan. See **Benefits & Coverage** for specific services that are covered or excluded.

Newborn coverage

Your dependent newborn is covered from birth. The plan does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one of the telephone numbers listed inside the front cover for more information. If additional premium is required, the plan is entitled to all premiums due from the time of the infant's birth until the time you notify the plan of the birth. The plan may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see **Eligibility and Enrollment**.

Pregnancy – maternity care

Benefits for your pregnancy care include medical services for prenatal care, labor and delivery, postnatal care, and related complications.

<u>Prenatal care</u>

Prenatal services include:

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

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

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

- Conditions that have arisen concurrently with the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or skin rash.
- Miscarriage and ectopic pregnancy.

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this plan. Please refer to those sections for coverage information.

Labor and delivery

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

Postnatal care

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

One home health care visit is covered if it occurs within 4 days of discharge. If services are received after 4 days, please refer to **Home Health Care** in **Benefits & Coverage** for benefits.

Newborns' and Mothers' Health Protection Act of 1996

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

For benefits and the amounts you pay, see **Benefits & Coverage**. Each covered person's admission is separate from the admission of any other covered person. A separate deductible and copayment or coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery. **Please note:** We encourage you to enroll your newborn dependent under the plan within 30 days from the date of birth, date of placement for adoption, or date of adoption. Please refer to **Eligibility and Enrollment** for additional information.

Physician services

In-network benefits apply to:

- Professional services received from a network provider;
- Emergency services from non-network providers will be covered as in-network benefits.

Post-mastectomy coverage

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

Prescription drugs

Preferred Drug List (PDL)

Medica's PDL identifies whether a drug is classified by Medica as a Tier 1, Tier 2, or Tier 3 covered drug. In general, only drugs on Medica's PDL are eligible for coverage.

The PDL is grouped into the following tiers:

Tier 1 is your lowest copayment or coinsurance option. For the lowest out-of-pocket expense, you should consider a Tier 1 covered drug if you and your physician decide it is appropriate for your treatment.

Tier 2 is your higher copayment or coinsurance option. You may consider a Tier 2 covered drug to treat your condition if you and your physician decide it is appropriate.

Tier 3 is your highest copayment or coinsurance option. The covered drugs in Tier 3 are usually more costly.

If you have questions about Medica's PDL or whether a specific drug is covered (and/or the PDL tier in which the drug may be covered), or if you would like to request a copy of the PDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The PDL is also available when you sign in at mymedica.com.

Medica selects drugs for the PDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a drug on the PDL, and the tier to which a drug is assigned, are based on the drug's safety, efficacy, uniqueness, and cost.

Exceptions to the PDL

Exceptions to the PDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the PDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's PDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's PDL for safety reasons. Medica will grant an exception to the PDL if the patient's health care provider indicates to us that any of the following apply: (a) the PDL drug causes an adverse reaction in the patient; (b) the PDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to

the patient, unless the drug was removed from Medica's PDL for safety reasons. If you would like to request a copy of Medica's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain covered drugs require prior authorization, as indicated on the PDL. The network provider who prescribes the drug initiates prior authorization. The PDL is made available to providers, including pharmacies and the designated mail order pharmacies. You are responsible for paying the cost of drugs received if you do not meet the plan's authorization criteria.

Step therapy

The plan requires a step therapy process prior to coverage of certain drugs, as indicated on the PDL. Step therapy involves trying an alternative covered drug first (typically a Tier 1 drug) before moving to a Tier 2 or Tier 3 covered drug for treatment of the same medical condition. Applicable step therapy requirements must be met before Medica will cover Tier 2 or Tier 3 covered drugs.

Quantity limits

Certain covered drugs are assigned quantity limits, as indicated on the PDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Mail order pharmacy benefits

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

Diabetic equipment and supplies (excluding blood glucose meters) are available via mail order if received from a designated mail order pharmacy.

Preventive drugs and other services, as specifically defined in **Definitions**, are eligible for mail order coverage. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service. **Note: Tobacco cessation products are not available through mail order.**

Retail pharmacy benefits

Retail pharmacy benefits include, but are not limited to:

- Preventive drugs and other services, as specifically defined in **Definitions**. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service.
- Diabetic equipment and supplies, including blood glucose meters.
- Tobacco cessation products prescribed by a provider authorized to prescribe the product.
- Insulin pumps, as covered under **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.

See **Prescription Specialty Drugs** in **Benefits & Coverage** for growth hormone and other specialty prescription drug coverage information.

Prescription specialty drugs

Designated specialty pharmacies

A designated specialty pharmacy means a specialty pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to covered persons. For the current list of designated specialty pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com.

Specialty Preferred Drug List (SPDL)

Medica has a tiered SPDL that identifies specialty prescription drugs that are covered, unless they are otherwise listed as not covered in this plan. The SPDL also identifies whether a drug is classified by Medica as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on Medica's SPDL are eligible for benefits under this plan.

The applicable copayments and coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefits table in **Prescription Specialty Drugs** in **Benefits & Coverage**.

If you have questions about Medica's SPDL or whether a specific specialty prescription drug is covered (and/or the SPDL tier in which the drug may be covered), or if you would like to request a copy of the SPDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The SPDL is also available by signing in at mymedica.com.

Medica selects specialty drugs for the SPDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a specialty drug on the SPDL, and the tier to which a specialty drug is assigned, are based on the specialty drug's safety, efficacy, uniqueness, and cost.

Exceptions to the SPDL

Exceptions to the SPDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the SPDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's SPDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's SPDL for safety reasons. Medica will grant an exception to the SPDL if the patient's health care provider indicates to us that any of the following apply: (a) the SPDL drug causes an adverse reaction in the patient; (b) the SPDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's SPDL for safety reasons. If you would like to request a copy of Medica's SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain specialty prescription drugs require prior authorization from Medica. The network provider who prescribes the specialty drug initiates prior authorization. The SPDL is made available to providers, including designated specialty pharmacies. You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria.

Step therapy

The plan requires step therapy prior to coverage of specific specialty prescription drugs as indicated on the SPDL. Step therapy involves trying an alternative covered specialty prescription drug (typically a Tier 1 specialty prescription drug) before moving to certain other Tier 1 or Tier 2 specialty prescription drugs for treatment of the same medical condition. Applicable step therapy requirements must be met before the plan will cover certain Tier 1 or Tier 2 specialty prescription drugs.

Quantity limits

Certain specialty prescription drugs are assigned quantity limits as indicated on the SPDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Specialty prescription drugs are not subject to the deductible.

Transplant services – organ and bone marrow

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

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

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

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

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

In-network benefits apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a hospital that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities.

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

There is no coverage for out-of-network benefits.

Weight loss surgery

In-network benefits apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or designated facility is a network physician or hospital that has been designated by Medica to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

There is no coverage for out-of-network benefits.

Exclusions

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

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

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

16. Custodial care, unskilled nursing, or unskilled rehabilitation services.
17. Respite or rest care, except as otherwise covered in **Hospice Services** in **Benefits & Coverage**.
18. Travel, transportation, or living expenses.
19. Household equipment, fixtures, home modifications, and vehicle modifications.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies, and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and amyotrophic lateral sclerosis.
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability, or any similar law.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by the plan, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **Benefits & Coverage**.
30. Dental prostheses.
31. Any orthodontia, except as described in **Medical-Related Dental Services** in **Benefits & Coverage** for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
34. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
35. Exams, other evaluations, or other services received solely for the purpose of employment, insurance, or licensure.
36. Exams, other evaluations, or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities unless otherwise covered under this plan.
37. Non-medical self-care or self-help training.

38. Educational classes, programs, or seminars, including but not limited to childbirth classes, except as described in **Physician Services** in **Benefits & Coverage**.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this plan.
42. Orthognathic surgery for cosmetic purposes.
43. Services for sex transformation operations.
44. Sensory integration, including auditory integration training.
45. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician Services** in **Benefits & Coverage**.
46. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders for covered persons 18 years of age and older. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
47. Health care professional services for home labor and delivery.
48. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
49. Services solely for or related to the treatment of snoring.
50. Interpreter services, except as described in **Home Health Care** in **Benefits & Coverage**.
51. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
52. Services for private duty nursing, except as described in **Home Health Care** in **Benefits & Coverage**. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the covered person or the covered person's representative, and not under the direction of a physician.
53. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
54. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
55. Health clubs.
56. Long-term care.
57. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements, or publications.

58. Any charges for mailing, interest, and delivery, such as the cost for mailing medical records.

Role of Medica

The plan administrator has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica's responsibilities generally consist of determining the validity of claims pursuant to the terms of the plan and administering benefit payments under this plan and determining the resolution of complaints and appeals pursuant to the terms of **Complaints**. The service agreement between the plan administrator and Medica is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. Medica is a third party retained by the plan administrator. Medica is not a COBRA administrator. The plan offers Medica Choice Passport.

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

This section describes how providers are generally paid for health services. See **Definitions** at the end of this document for defined terms and phrases.

Network providers

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

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

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

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

Risk-sharing payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per covered person, or an amount

per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a covered person's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a covered person's health services, the network provider may keep some of the excess.

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

Withhold arrangements

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

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

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

Harmful Use of Medical Services

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

When this section applies

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

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

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

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

Medica will send you specific information about:

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

How to Submit a Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

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

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

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

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

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

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

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

Claims for services provided outside the United States

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

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

- Such other documentation as the plan may request.

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

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

Time limits

If you have a complaint or disagree with a decision by the plan, you may follow the complaint procedure outlined in **Complaints**.

Coordination of Benefits

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

Applicability

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

Definitions that apply to this section

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

   Each contract or other arrangement for coverage under a. or b. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
2. This plan is the part of the plan that provides benefits for health care expenses.
3. *Primary plan/secondary plan.* The **Order of benefit determination rules** state whether this plan is a primary plan or secondary plan as to another plan covering the person.

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

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

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

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

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

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

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

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

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

Order of benefit determination rules

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

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

   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.

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

   a. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, covered person, or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

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

   i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   ii. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in 2.b.i. immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

   i. First, the plan of the parent with custody of the child;

   ii. Then, the plan of the spouse of the parent with the custody of the child; and

   iii. Finally, the plan of the parent not having custody of the child.

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

d. *Joint custody*. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the **Order of benefit determination rules** outlined in 2.b.

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

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

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

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

Effect on the benefits of this plan

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

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

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

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

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

   When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under the plan, according to the out-of-network benefits described. Most out-of-network benefits are covered at 50 percent of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

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

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

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

Please note: See **Right of Recovery** for additional information.

Right of Recovery

This section describes this plan's right of recovery. This plan's rights may be subject to Minnesota and federal law. For information about the effect of applicable state and federal law on this plan's subrogation rights, contact an attorney.

See **Definitions** at the end of this document for defined terms and phrases.

1. This plan has a right of subrogation against any third party, individual, corporation, insurer, or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. This plan's right of subrogation shall be governed according to this section. This plan's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. This plan's subrogation interest is the reasonable cash value of any benefits received by you.
3. This plan's right to recover its subrogation interest may be subject to an obligation by the plan to pay a pro rata share of your disbursements, attorney fees, and costs you pay in obtaining your recovery.
4. By accepting coverage under the plan, you agree:
    a. To cooperate with the plan administrator, sponsor, or plan designee to help protect the plan's legal rights under this subrogation provision and to provide all information the plan may reasonably request to determine its rights under this provision.
    b. To provide prompt written notice to the plan administrator when you make a claim against a party for injuries.
    c. To provide prompt written notice of the plan's subrogation rights to any party against whom you assert a claim for injuries.
    d. To do nothing to decrease the plan's rights under this provision, either before or after receiving benefits.
    e. The plan may take action to preserve its legal rights. This includes bringing suit in your name.
    f. The plan may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative, or the legal representative(s) of your estate or next-of-kin.
    g. To hold in trust the proceeds of any settlement or judgment for the plan's benefit under this provision.

Eligibility and Enrollment

This section describes who can enroll and how to enroll.

Who can enroll

All qualified employees and dependents as defined in **Definitions** are eligible for coverage under this plan. In order for an eligible dependent to enroll in the plan, the qualified employee must also be enrolled.

How to enroll

Submit an application for coverage for the qualified employee and/or any dependents to the plan administrator:

1. During the initial enrollment period as described in this section under **Initial enrollment and effective date of coverage**; or
2. During the open enrollment period as described in this section under **Open enrollment and effective date of coverage**; or
3. During a special enrollment period as described in this section under **Special enrollment and effective date of coverage**; or
4. At any other time as a late enrollee as described in this section under **Late enrollment and effective date of coverage**.

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

Initial enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and/or any dependents to the plan administrator during the initial enrollment period, which will be communicated to the qualified employee by the plan administrator.

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

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

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the first of the month following 30 days (one month) of employment.

Open enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and any dependents to the plan administrator during the open enrollment period, which will be communicated to the qualified employee by the plan administrator. Open enrollment period means the period of time occurring toward the end of the calendar year during which qualified employees and eligible dependents who are not covered under the plan may elect to begin coverage effective the first day of the upcoming calendar year.

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

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

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified employees and dependents under certain circumstances. Qualified employees and dependents who are eligible to enroll during a special enrollment period may enroll in any medical benefit package or option available to similarly situated individuals who enroll when first eligible. **However, all other provisions of the plan, including but not limited to provisions setting a lifetime maximum on benefits, will apply to special enrollees.**

1. Loss of other coverage

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

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

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under creditable coverage other than Medicaid or a State Children's Health Insurance Plan at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment, and declined coverage for that reason.

    The qualified employee or dependent must present to the plan administrator either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated, and

request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

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

ii. Loss of eligibility includes:

- loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
- cessation of dependent status;
- incurring a claim that causes the qualified employee or dependent to meet or exceed the lifetime maximum limit on all benefits;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the qualified employee or dependent.

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

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

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent that has lost coverage and the qualified employee; dependents will not be enrolled without the qualified employee also being enrolled.

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

The qualified employee or dependent must present to the plan administrator evidence that the qualified employee or dependent has exhausted such COBRA or

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

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
- losing coverage as a result of the employer's failure to remit premiums on a timely basis; or
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

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

iii. In the case of the qualified employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee; dependents will not be enrolled without the qualified employee also being enrolled.

2. The dependent is a new spouse of the enrollee or qualified employee, provided that the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided that the qualified employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided that enrollment is requested in writing within 30 days of the enrollee or qualified employee acquiring the dependent and provided that the qualified employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption, or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the enrollee acquires the dependent child.

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

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the plan; and

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

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

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

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

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

7. When the qualified employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children's Health Insurance Plan. The qualified employee must request enrollment within 60 days after the date the employee or dependent is determined to be eligible for premium assistance.

   In the case of the qualified employee becoming eligible for premium assistance, this special enrollment period applies to the qualified employee and all of his or her dependents. In the case of a dependent becoming eligible for premium assistance, this special enrollment period applies to both that dependent and the qualified employee. Coverage is effective the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator.

Late enrollment and effective date of coverage

The plan allows enrollment as a late enrollee for qualified employees and eligible dependents enrolling outside of the initial enrollment period, the open enrollment period, or any special enrollment period described in this section.

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

Coverage will be effective the first day of the month following the date of the plan administrator's approval of the request for enrollment.

Medical Support Order

The plan is intended to comply with the requirements of applicable Minnesota law regarding medical support orders. This may result in the delay of a termination of coverage as described in **Ending Coverage**. Notwithstanding any provision of this plan to the contrary, this plan shall recognize support orders that address medical coverage for dependent children and former spouses in accordance with the requirements under Section 518A.41 of the Minnesota Statutes as determined by the plan administrator according to its policy relating to the plan established for the purpose of complying with these requirements.

Ending Coverage

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

When your coverage ends

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

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The end of the month for which the enrollee or covered person last paid any required contribution to the plan.
3. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. See **Eligibility and Enrollment** for information on eligibility.
4. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
5. The end of the month following the date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
6. The date specified by the plan administrator because a covered person permitted the use of his or her identification card by any unauthorized person or used another person's card or submitted fraudulent claims.
7. The end of the month in which a covered person enters active military duty for more than 31 days. Upon completion of active military duty, contact the plan administrator to discuss reinstatement of coverage.
8. The date specified by the plan administrator in written notice to a covered person that coverage ended due to the plan administrator's determination that the covered person committed fraud in applying for this coverage or for any of its benefits. Fraud includes, but is not limited to, intentionally providing the plan administrator with false material information such as:

    a. Information related to an enrollee's eligibility or another person's eligibility for coverage or status as a dependent; or

    b. Information related to an enrollee's health status or that of any dependent; or

    c. Intentional misrepresentation of the employer-employee relationship.

    Coverage will be retroactively terminated at the plan administrator's discretion to the original date of coverage or the date on which the fraudulent act took place. No continuation privilege will be extended.

Continuation

Required continuation coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under state law, federal law, or both. All aspects of continuation coverage administration are the responsibility of the plan administrator.

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

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

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

Your right to continue coverage under state law

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

1. **Minnesota state continuation coverage.**

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

2. **Notice of rights.**

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

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

Enrollee's loss

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

Enrollee's spouse's loss

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

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. Dissolution of marriage from the enrollee;
4. The enrollee's enrollment for benefits under Medicare.

Enrollee's child's loss

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

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. Termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. The enrollee's dissolution of marriage from the child's other parent;
4. The enrollee's enrollment for benefits under Medicare if the enrollee is the parent through whom the child receives coverage;
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

Election rights

When the plan administrator is notified that one of these events has happened, the enrollee and the enrollee's dependents will be notified of the right to continuation coverage.

Consistent with Minnesota law, the enrollee and dependents have 60 days to elect continuation coverage for reasons of termination of the enrollee's employment or the enrollee's enrollment for benefits under Medicare measured from the later of:

1. The date coverage would be lost because of one of the events described above; or
2. The date notice of election rights is received.

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

The enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. Under certain circumstances, the enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

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

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the sponsor of all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage.

Surviving dependents of a deceased enrollee have 90 days after notice of the requirement to pay continuation premiums to make the first payment.

Duration

Under the circumstances described above and for a certain period of time, Minnesota law requires that the enrollee and his or her dependents be allowed to maintain continuation coverage as follows:

1. For instances where coverage is lost due to the enrollee's termination of or layoff from employment, coverage may be continued until the earliest of:
    a. 18 months after the date of the termination of or layoff from employment;
    b. The date the enrollee becomes covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
    c. The date coverage would otherwise terminate under the plan.

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

    If a dissolution of marriage occurs during the period of time when the enrollee s spouse is continuing coverage due to the enrollee's termination of or layoff from employment, coverage of the enrollee's spouse may be continued until the earlier of:
    a. The date the former spouse becomes covered under another group health plan; or
    b. The date coverage would otherwise terminate under the plan.
5. If coverage is lost because of the enrollee's absence from work due to total disability, coverage of the enrollee and any dependents may be continued until the date coverage would otherwise terminate under the plan.
6. Upon the death of the enrollee, the coverage of a enrollee's spouse or dependent children may be continued until the earlier of:
    a. The date the surviving spouse and dependent children become covered under another group health plan; or
    b. The date coverage would have terminated under the plan had the enrollee lived.

Extension of benefits for total disability of the enrollee

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

Your right to continue coverage under federal law

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

COBRA continuation coverage

Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended as it applies to state governmental entities through the Public Health Service Act (PHSA), as amended. The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General COBRA information in this section. In addition, continuation of coverage requirements under Minnesota law shall be followed as described in this section.

USERRA continuation coverage

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

General COBRA information

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

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

Qualified beneficiary

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

1. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);
2. A covered spouse of a covered employee; or
3. A dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Enrollee's loss

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

Enrollee's spouse's loss

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

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. Divorce or legal separation from the enrollee; or
4. The enrollee's entitlement to (actual coverage under) Medicare.

Enrollee's child's loss

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

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. The enrollee's termination of employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. The enrollee's divorce or legal separation from the child's other parent;
4. The enrollee's entitlement to (actual coverage under) Medicare if the enrollee is the parent through whom the child receives coverage; or
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator of that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the plan administrator within 30 days of the determination.

Bankruptcy

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

Election rights

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

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

1. The date coverage would be lost because of one of the events described above, or
2. The date notice of election rights is received.

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

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

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

Type of coverage and cost

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

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

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

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the plan because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended if a second event (e.g., divorce, legal separation, or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's covered dependent who is determined to be disabled under the Social Security Act at the time of

the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period.

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

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

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

1. The enrollee's employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
4. The enrollee becomes entitled to (actually covered under) Medicare.

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

General USERRA information

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

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

Employee's loss

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

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and the

time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

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

Election rights

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

Type of coverage and cost

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

Duration of USERRA coverage

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

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

1. The employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;
4. The employee fails to return to work following the completion of his or her service in the uniformed services; or
5. The employee returns to work and is reinstated under the plan as an active employee.

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

COBRA and USERRA coverage are concurrent

If the employer is subject to both COBRA and USERRA, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

Other continuation coverage

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

Retiree coverage

Retiree coverage shall be provided in accordance with Section 471.61 of the Minnesota Statutes for a retiree and his or her dependents enrolled under the plan immediately preceding the enrollee's retirement. Sponsor may pay a portion of the premium for such coverage. Eligibility with respect to the availability of continuation coverage beyond the requirements of Minnesota Statutes Section 471.61 shall be determined by sponsor, pursuant to its Policy and Procedure. The retiree coverage may run concurrently with any available COBRA or state continuation coverage or the retiree coverage may be offered in lieu of the COBRA or state continuation coverage.

Surviving spouse

The surviving spouse (widow or widower) of a qualified employee or a retiree will remain eligible for coverage under this plan if:

1. Both the spouse and the qualified employee or retiree were covered persons under the plan at the time of the qualified employee's or retiree's death; and
2. The surviving spouse remains unmarried.

The sponsor may pay a portion of the premium for such coverage. Any available COBRA or state continuation coverage may run concurrently with surviving spouse coverage.

Leaves of absence

An enrollee on a leave of absence from employment with the sponsor and that is approved by the sponsor may be entitled to continuation coverage. The sponsor may pay a portion of the premium for such coverage. Eligibility, as it pertains to the availability of continuation coverage during a leave of absence, shall be determined by the sponsor, in accordance with its leave of absence policy. Any available COBRA or state continuation coverage may run concurrently with leave of absence coverage.

Insurability

A person does not have to demonstrate insurability to elect continuation coverage. At the end of the 18, 24, 29, or 36-month continuation period, as applicable, there is no opportunity to enroll in an individual conversion health plan.

Complaints

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

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in **First level of review**. You may also contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 539-1600 or 1-800-657-3602.

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

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

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

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

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

First level of review

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

Complaints that do not involve a medical necessity review by Medica:

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

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

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

2. For a written complaint, Medica will provide written notice of its first level of review decision to you within 30 days from initial receipt of your complaint.
3. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described below, must be exhausted before you have the right to submit a request for external review.

Complaints that involve a medical necessity review by Medica:

1. Your complaint must be made within one year following Medica's initial decision and may be made orally or in writing.
2. Medica will provide written notice of its first level of review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint.
3. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review, you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.
4. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level of review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.
5. If your complaint involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of the review process.

Second level of review

If you are not satisfied with Medica's first level of review decision, you may request a second level of review through either a written reconsideration or a hearing.

1. Your request can be oral or in writing. It must be provided to Medica within one year following the date of Medica's first level review decision. If your request is in writing, it must be sent to the address listed above in **First level of review**.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation, or other information provided by you, Medica staff, providers, and others is reviewed.

3. Medica will provide written notice of its second level of review decision to you within:

   a. 30 calendar days from receipt of written notice of your appeal for required second level of review; or

   b. 45 calendar days from receipt of written notice of your appeal for optional second level of review.

   For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. Generally, a second level of review is optional if the complaint requires a medical necessity review. Medica will inform you in writing whether the second level of review is optional or required.

External review

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

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

You must submit your written request for external review within six months from the date of Medica's decision. You must include a filing fee of $25 with your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. Contact the Commissioner of Commerce for more information about the external review process.

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

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

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

General Provisions

This section describes the general provisions of the plan.

Records

The sponsor, the plan administrator, Medica, and others to whom the sponsor has delegated duties and responsibilities under the plan shall keep accurate and detailed records of any matters pertaining to administration of the plan in compliance with applicable law.

Examination of a covered person

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

Clerical error and misstatements

Should a clerical error be found or should any misstatement of relevant facts pertaining to coverage under the plan be found, and should such error or misstatement affect the existence or amount of coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage. For example, you will not be eligible for coverage beyond the scheduled termination of coverage because of a failure to record the termination. On the other hand, you will not be deprived of coverage under the plan because of a clerical error.

Plan amendment and termination

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

Applicable law

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

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) imposes certain obligations on employers. This plan shall be administered in a manner consistent with USERRA.

Enrollee rights

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

Family and Medical Leave Act of 1993 (FMLA)

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

Reservation of discretion

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

Definitions

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

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

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

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

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

Coinsurance. The percentage amount you must pay to the provider for benefits received. Full coinsurance payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

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

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

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

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

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

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

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

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

Convenience care/retail health clinic. A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, which provides treatment of common illnesses and certain preventive health care services.

Copayment. The fixed dollar amount you must pay to the provider for benefits received. Full copayments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

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

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

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not medically necessary, or as determined by the plan.

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

Creditable coverage. Health coverage provided under one of the following plans:

1. A group health benefit plan, including a self-insured plan;
2. Health insurance coverage, whether through a group or individual contract;
3. Medicare;

4. Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines);
5. A state health benefit risk pool;
6. A military health plan or other coverage provided under United States Code, title 10, chapter 55;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. The Federal Employees Health Benefits Program or other similar coverage provided under federal law applicable to government organizations and employees;
9. A health benefit plan provided under Section 5(e) of the federal Peace Corps Act;
10. State Children's Health Insurance Program; or
11. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.

Coverages of the following types, including any combination of the following types, are *not* creditable coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance;
4. Workers' compensation insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Limited scope dental or vision coverage;
9. Coverage for long-term care, nursing home care, home health care, community-based care, or any combination of these;
10. Coverage only for a specified disease or illness;
11. Hospital indemnity or other fixed indemnity insurance; or
12. Medicare supplemental health insurance, benefits supplemental to military health care, and similar supplemental coverage if such benefits are provided under a separate policy or contract of insurance.

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

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

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

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

   For residents of a state other than Minnesota, the dependent limiting age may be higher if required by applicable state law.
3. The enrollee's or enrollee's spouse's disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. This dependent may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.
4. The enrollee's or enrollee's spouse's disabled dependent who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability and dependency at the time of the dependent's enrollment.

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

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

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

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

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

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

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

Enrollment date. The date of the qualified employee's or dependent's first day of coverage under the plan or, if earlier, the first day of the waiting period for the qualified employee's or dependent's enrollment.

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

Habilitative. Health care services are considered habilitative when they are provided to improve an impairment in physical function or speech due to congenital or developmental conditions, including autism spectrum disorders, that have impeded normal speech and motor development.

HIPAA privacy standards. Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended, and codified at 45 CFR Parts 160 and 164.

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

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

Investigative. As determined by the plan, 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. The plan will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

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

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

Late enrollee. A qualified employee or dependent who requests enrollment under the plan other than during:

1. The initial enrollment period set by the sponsor; or
2. The open enrollment period set by the sponsor; or
3. A special enrollment period as described in **Eligibility and Enrollment**.

In addition, a covered person who is a child entitled to receive coverage through a medical support order is not subject to any initial or open enrollment period restrictions.

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

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

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

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

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

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility, or pharmacy) that has entered into a written agreement to provide benefits to you. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically, without charge.

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

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

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

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

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

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

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

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

There are separate in-network and out-of-network out-of-pocket maximums for this plan. Once your out-of-pocket maximum for in-network and out-of-network is met, then other benefits in the same category are covered at 100 percent. For example, if your eligible out-of-pocket maximum for in-network benefits is met, all in-network benefits for the remainder of the calendar year are covered at 100 percent, but your out-of-network benefits will not be covered at 100 percent until that out-of-pocket maximum is met.

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

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

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

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

Placed for adoption. The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child. Eligibility for a child placed for adoption with the enrollee ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.

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

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

Plan administrator. Sibley/McLeod County.

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

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

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

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

Contact Customer Service for information regarding specific preventive health services, services that are rated A or B, and services that are included in guidelines supported by the Health Resources and Services Administration. For a list of preventive health services please sign in at medica.com.

Protected health information or PHI. With some exceptions, information that: (i) identifies or could reasonably be used to identify you; and (ii) relates to your physical or mental health or condition, the provision of your health care, or your payment for health care.

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

Qualified employee. An employee of sponsor. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the

sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

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

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your physician.

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

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

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

Retiree. A former employee who is an enrollee under the plan immediately preceding retirement and who, upon retirement:

1. Is receiving a disability benefit from a Minnesota public pension plan other than a volunteer firefighter plan or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan; or
2. Has met age and service requirements to receive an annuity from such a plan as described in 1. above.

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

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

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

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

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

Skilled care. Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for skilled care.

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

Sponsor. Sibley/McLeod County.

Total disability. Disability due to injury, sickness, or pregnancy that requires regular care and attendance of a physician, and in the opinion of the physician renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability and, after the first two years of the disability, renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted.

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

Virtual care. Professional evaluation and medical management services provided to patients through e-mail, telephone, or webcam. Virtual care includes interactive audiovisual telehealth services. Virtual care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results, or solely calling in a prescription to a pharmacy.

Waiting period. In accordance with applicable state and federal laws, the period of time, as determined by the sponsor's eligibility requirements, that must pass before a qualified employee and/or dependent becomes covered under the plan. However, if a qualified employee and/or dependent enrolls as a late enrollee or through either an open enrollment period or a special enrollment period as set forth herein in **Eligibility and Enrollment**, any period before such late, open, or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Signature

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

Sibley County

By: _____
(please print)

_____
(signature)

Its: _____

McLeod County

By: _____
(please print)

_____
(signature)

Its: _____

MEDICA®

Medica Choice Passport

SIBLEY/MCLEOD HEALTH INSURANCE PLAN HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

Administered by Medica Self-Insured

SIBLEY/MCLEOD COUNTY

MEDICA CHOICE PASSPORT 3000-0% HSA

BPL #29440

GROUP #53052, 53053

JANUARY 1, 2016

MEDICA CUSTOMER SERVICE

Minneapolis/St. Paul Metro Area:
(952) 945-8000

Outside the Metro Area:
1-800-952-3455

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

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

هذه المعلومات إتصل بالرقم الموجود على ظهر بطاقة
اذا كنت تحتاج مساعدة مجانية في ترجمة هذه المعلومات
التعريف الطبية الخاصة لك Medica

Haddii aad doonayso in Af Soomaali laguugu tarjamadda macluumaadkani, oo lacag la'aan ah, Fadlan wac Lambarka ku qoran Kaarka Caafimaadka ee Medica dhabarkiisa.

Ako zelite besplatano tumacenje ovih informacija posovite broj na pozadini vase Medica kartice.

Yog koj xav tau kev pab txhais cov ntaub ntawv no dawb, hu rau tus xov tooj nyob nram qab koj daim Medica Khaj (card).

ຖ້າທ່ານຕ້ອງໃຫ້ຊ່ວຍແປພາສາ ຖືຂໍ້ມູນເຫຼົ່ານີ້ ຈົ່ງໂທຄວາມເລກ ທີ່ໃຫ້ໄວ້ຢູ່ຂ້າງຫຼັງ ເມດິກາ ຖືບັດ ກວດສຸຂະພາບ?ຈຶ່ງການເນັ້ນ Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

ប្រសិនបើអ្នកចង់បានការជួយបកប្រែដោយឥតគិតថ្លៃពីព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខទូរស័ព្ទ នៅខាងក្នុងកាតអេម៉ឺរ៉ា Medica ។

Si usted desea ayuda gratuita para traducir esta información, llame al número de teléfono situado al reverso de su tarjeta de identificación de Medica.

Nếu quý vị muốn được giúp đỡ dịch tài liệu này miễn phí, xin gọi số ghi ở mặt sau thẻ Medica cua quý vị.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.

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Introduction

See **Definitions** at the end of this document for defined terms and phrases.

Sibley/McLeod County (sponsor) has established the Sibley/McLeod Health Insurance Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Sibley/McLeod County (plan administrator). This plan was originally established January 1, 1993. This restatement of the plan is effective January 1, 2016 unless specifically stated otherwise.

The plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code) and applicable Minnesota law, including but not limited to Section 471.617 of the Minnesota Statutes.

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

In this plan, the words you, your, and yourself refer to the covered person. The word sponsor refers to the organization through which you are eligible for coverage.

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

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

What you must do to be eligible for benefits

Each time you receive health services, you must:

1. Confirm with Customer Service that your provider is a network provider with Medica Choice Passport; and
2. Identify yourself as a covered person under the plan; and
3. Present your plan identification card. However, possession and use of a plan identification card does not necessarily guarantee coverage.

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

If you need language interpretation

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

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

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

Medica's nondiscrimination policy

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

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

Health savings accounts

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

Plan Overview

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

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this document. Please contact Customer Service to make such a request. **If this plan is translated into another language, this written English version governs all coverage decisions.**

General plan information

Plan Name

Sibley/McLeod Health Insurance Plan

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

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

- McLeod County
  Pat Melvin, County Administrator
  830 11th Street E.
  Glencoe, MN 55336
- Sibley County
  Kim Moore, Human Resource Director
  PO Box 256, 400 Court Avenue
  Gaylord, MN 55334

Agent for Service of Legal Process

Sibley County Attorney

Sponsor IRS Employer Identification Number (EIN)

McLeod County 41-6005841

Sibley County 41-6005897

Plan Year

January 1 through December 31

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network; claims processing services; and complaint resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from the general assets of sponsor. You may be responsible for a portion of the cost of the coverage provided under this plan. The portion of the cost of coverage for which the enrollee is responsible may be paid on a pre-tax basis through a cafeteria plan of sponsor if such a plan is made available by sponsor.

Benefits

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

The benefits described in this plan document detail the medical benefits available under the plan. **Benefits & Coverage** describes the coinsurance and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain things be done first (i.e., prior authorization be obtained). Not following these requirements may

impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **Exclusions**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right of Recovery**.

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

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

copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:

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

       For McLeod County: County Auditor, County Administrator, Technical Specialist III (Auditor); For Sibley County: Human Resource Coordinator, Payroll Coordinator, Auditor

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

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

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

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

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

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

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

Before You Access Care

This section provides information for you to consider before you access care.

Provider network

In-network benefits are available through the Medica Choice Passport provider network. To see which providers are in your plan's network, check the online search tool on mymedica.com or contact Customer Service.

If you access services from providers that are not contracted with Medica, out-of-network benefits will apply.

Referrals

If you obtain a referral for services that you'll receive from a non-network provider (or certain types of network providers), you must get prior authorization from Medica to get your best benefit.

Prior authorization

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

Prior authorization from the plan may be required before you receive certain services or supplies. Medica uses written procedures and criteria when reviewing your request for prior authorization to determine whether a particular service or supply is medically necessary and is a covered benefit. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com. Emergency services do not require prior authorization.

You, someone on your behalf, or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Customer Service to request prior authorization for a service or supply. You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to obtain prior authorization after you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

Obstetrics/gynecology services do not require prior authorization and will be covered at the in-network or out-of-network benefit level, as applicable.

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

- Reconstructive or restorative surgery;

- Certain drugs;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests; and
- Skilled nursing facility services.

Prior authorization is always required for:

- Organ and bone marrow transplant services; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

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

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

- 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); and
- Other applicable covered person information (i.e., plan identification number).

Medica will review your request and provide a response to you and your attending provider 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.

Both you and your provider will be informed of the decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or if it is concluded that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting.

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

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

Benefits

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

Under certain circumstances, Medica will authorize non-network provider services at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services aren't available from network providers.

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

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

- Discuss the expected billed charges with the non-network provider; and
- Contact Customer Service to verify the estimated amount Medica would pay for those services; and
- Calculate your likely out-of-pocket expenses; and
- If you wish to request that the plan authorize the non-network provider's services be covered at the in-network benefit level, follow the procedure to request prior authorization described in this section.

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

Scenario:

You choose to receive non-emergency inpatient care at a non-network hospital without an authorization from the plan. The out-of-network benefits apply to these services.

Assumptions:

1. You have previously satisfied your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. Medica's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally as a percentage coinsurance. In this scenario, we will use 40% coinsurance.
    b. In addition, the non-network provider will likely bill you for the amount that their charge exceeds what Medica reimburses them.
4. For this non-network hospital stay, you will be required to pay:
    - 40% coinsurance (40% of $15,000 = $6,000) and

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

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

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

The $15,000 amount you pay for billed charges in excess of the non-network provider reimbursement amount *will not* be applied toward the out-of-pocket maximum.

You will owe the provider this $15,000 amount regardless of whether you have previously reached your out-of-pocket maximum.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services received.

Claims

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

Continuity of care

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

In certain situations, you have a right to continuity of care:

1. If your current provider is terminated without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are new to Medica as a result of the sponsor changing its third party administrator 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.

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

Upon request, the plan will authorize continuity of care for up to 120 days as described in 1. and 2. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;

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

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

Upon request, Medica will authorize continuity of care for up to 120 days as described in 1. and 2. above in the following situations:

- if you are receiving culturally appropriate services and a network provider who has special expertise in the delivery of those culturally appropriate services is not available; or
- if you do not speak English and a network provider who can communicate with you, either directly or through an interpreter, is not available.

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

Benefits & Coverage

This section describes the services eligible for coverage and the expenses that are your responsibility to pay.

More detail about the services, procedures, drugs, and supplies that are covered can be found in **Covered Health Services**.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND LIFETIME MAXIMUM

Deductibles

Your plan may require that you meet a deductible amount before your claims for services are covered. The table below will indicate whether or not your plan has a deductible and where it will apply.

Out-of-pocket maximum

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

Please note: Charges for services that aren't covered and charges a non-network provider bills you that are in excess of the non-network provider reimbursement amount will not apply toward your out-of-pocket maximum. You will owe these amounts even if you had already reached your out-of-pocket maximum with amounts paid for other services.

Lifetime maximum amount

This is the maximum amount the sponsor will pay for covered out-of-network services that you receive while you are covered under this plan or any and all other benefit plans, programs, or arrangements offered by the sponsor. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential health benefits as defined in the Patient Protection and Affordable Care Act, including any amendments, regulations, rules, or other guidance issued with respect to the Act. Note, that if you reach a lifetime benefit maximum under one benefit package, option, plan, program, or arrangement offered by sponsor and either change packages, options, plans, programs, or arrangements offered by sponsor at open enrollment or under a special enrollment opportunity, the amounts paid for benefits under the first benefit package, option, plan, program, or arrangement will carry forward and count towards the applicable lifetime maximum benefit under the second benefit package, option, plan, program, or arrangement offered by sponsor. In other words, the lifetime maximum does not start anew.

Deductibles, Out-Of-Pocket Maximums, and Lifetime Maximum		
	Your cost if you visit an:	
	In-network provider	Out-of-network provider
Coinsurance	See specific benefit for applicable coinsurance.	
Deductible		
Per covered person	$3,000	$4,500
Per family	$6,000	$9,000
When covered persons in a family unit (an enrollee and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year, then all covered persons of the family unit are considered to have satisfied the applicable per covered person and per family deductible for that calendar year.		
Out-of-pocket maximum		
Per covered person	$3,000	$7,000
Per family	$6,000	Per family out-of-pocket maximum does not apply. Refer to the per covered person out-of-pocket maximum above.
When covered persons in a family unit (an enrollee and his or her dependents) have together met the applicable per family out-of-pocket maximum for benefits received during the calendar year, then all covered persons of the family unit are considered to have met the applicable per covered person and per family out-of-pocket maximum for that calendar year.		
Lifetime maximum amount payable per covered person	Unlimited	$1,000,000. Applies to all benefits you receive under this plan or that you have received under another benefit package, option, plan, program, or arrangement offered by sponsor prior to participation in this plan.

Covered benefits and the amounts you pay

Important information

- Prior authorization from the plan may be required before you receive some services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See **Before You Access Care** for more information about the prior authorization process.
- For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. These charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum. Please see **Benefits** in **Before You Access Care** for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.
- Any day, visit, or service limitation in this section includes days, visits, or services that you pay for in order to satisfy any part of your applicable deductible.

AMBULANCE

See **Covered Health Services** for more information about ambulance services.

Ambulance		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Emergency ambulance services or emergency ambulance transportation	Nothing	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service – see eligibility criteria below	Nothing	20% coinsurance

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

1. Transportation is from hospital to hospital, and
   a. Care for your condition isn't available at the hospital where you were first admitted; or
   b. If it is required by the plan; or
2. Transportation is from hospital to skilled nursing facility.

Not covered:

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

ANESTHESIA

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

Anesthesia		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Anesthesia services received in a non-inpatient setting	Nothing	20% coinsurance
2. Anesthesia services received during an inpatient stay	Nothing	20% coinsurance

BEHAVIORAL HEALTH – MENTAL HEALTH

Prior authorization. For mental health prior authorization requirements, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Office visits, including evaluations, diagnostic, and treatment services	Nothing	20% coinsurance
2. Intensive outpatient programs	Nothing	20% coinsurance

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional. Examples of such therapy include applied behavioral analysis, intensive early intervention behavior therapy, and intensive behavioral intervention.	Nothing	20% coinsurance
4. Inpatient services (including residential treatment services) **Note:** These services include inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children.		
a. Room and board	Nothing	20% coinsurance
b. Hospital or facility-based professional services	Nothing	20% coinsurance
c. Attending psychiatrist services	Nothing	20% coinsurance
d. Partial program	Nothing	20% coinsurance

Not covered:

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

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Prior authorization. For prior authorization requirements of in-network and out-of-network benefits, call the designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center at 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Substance Abuse		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Office visits, including evaluations, diagnostic, and treatment services	Nothing	20% coinsurance
2. Intensive outpatient programs	Nothing	20% coinsurance
3. Opiate replacement therapy	Nothing	20% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	Nothing	20% coinsurance
b. Hospital or facility-based professional services	Nothing	20% coinsurance
c. Attending physician services	Nothing	20% coinsurance

Not covered:

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

7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

CLINICAL TRIALS

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

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND MEDICAL SUPPLIES

See **Covered Health Services** for more information about durable medical equipment, prosthetics, and medical supplies.

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Durable medical equipment and certain related supplies	Nothing	20% coinsurance
2. Prosthetics: a. External prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet, and hands; ii. Artificial eyes, ears, and noses; iii. Breast prostheses b. Scalp hair prostheses due to alopecia areata – limited to one prosthesis (i.e. wig) per covered person per calendar year c. Repair, replacement, or revision of prostheses made necessary by normal wear and use	Nothing	20% coinsurance
3. Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures	Nothing. Coverage is limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	20% coinsurance. Coverage is limited to one hearing aid per ear every three years.
4. Breast pumps	Nothing. The deductible does not apply.	20% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
5. Medical supplies: a. Blood clotting factors b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and	Nothing	20% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6. Eligible ostomy supplies	Nothing	20% coinsurance
7. Insulin pumps and other eligible diabetic equipment and supplies	Nothing	20% coinsurance

Not covered:

1. Durable medical equipment, supplies, prosthetics, appliances, and hearing aids not on the plan eligible list.
2. Charges in excess of the plan standard model of durable medical equipment, prosthetics, or hearing aids.
3. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, except when made necessary by normal wear and use.
4. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, due to loss, damage, or theft.
5. Duplicate durable medical equipment, prosthetics, and hearing aids, including repair, replacement, or revision of duplicate items.
6. Other disposable supplies and appliances, except as described in **Benefits & Coverage** or **Covered Health Services**.

EMERGENCY ROOM CARE

Emergency services from non-network providers will be covered as in-network benefits. If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-

network benefits until your attending physician agrees it is safe to transfer you to a network facility.

See **Covered Health Services** for more information about emergency room care.

Emergency Room Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Services provided in a hospital or facility-based emergency room	Nothing	Covered as an in-network benefit.
2.	Services received from a physician during an emergency room visit	Nothing	Covered as an in-network benefit.

GENETIC TESTING AND COUNSELING

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

Genetic Testing and Counseling		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically **Please note:** Genetic counseling for BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing	20% coinsurance

HOME HEALTH CARE

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

See **Covered Health Services** for more information.

Home Health Care		
	Your cost if you use an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Skilled physical, speech, or occupational therapy when you are homebound	Nothing	20% coinsurance

Home Health Care			
	Benefits	Your cost if you use an: In-network provider, after deductible:	Out-of-network provider, after deductible:
	c. Home infusion therapy Benefits covered under a. and b. above are limited to a combined maximum of 120 visits per calendar year for in-network and 60 visits per calendar year for out-of-network benefits. If you have Medica coverage and are also enrolled in the Medical Assistance Program, you may be eligible for additional intermittent skilled care.		
2.	Services received in your home from a physician	Nothing	20% coinsurance

Not covered:

1. Companion, homemaker, and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech, or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** and **Prescription Drugs** in **Benefits & Coverage**.

12. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.
14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

HOSPICE SERVICES

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

See **Covered Health Services** for more information.

Hospice Services			
		Your cost if you use an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Hospice services	Nothing	20% coinsurance

Not covered:

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

HOSPITAL SERVICES

Hospital and ambulatory surgical center services are covered. A physician must direct your care.

Hospital Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Outpatient hospital or ambulatory surgical center services	Nothing	20% coinsurance
2. Services provided in a hospital observation room	Nothing	20% coinsurance
3. Inpatient services For associated professional services, see **Physician Services** in **Benefits & Coverage**.	Nothing	20% coinsurance

Not covered:

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.
2. Transfers and admissions to network hospitals solely at the convenience of the covered person.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY TREATMENT

Coverage for infertility treatment is limited to a maximum of $5,000 per covered person per calendar year for in-network and out-of-network benefits combined.

In-network benefits apply to infertility services received from a network provider.

Out-of-network benefits apply to infertility services received from a non-network provider.

See **Covered Health Services** for more information.

Infertility Treatment			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Office visits, including any services provided during such visits	Nothing	20% coinsurance
2.	Outpatient services received at a hospital	Nothing	20% coinsurance
3.	Inpatient services	Nothing	20% coinsurance
4.	Services received from a physician during an inpatient stay	Nothing	20% coinsurance

Not covered:

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage**.
2. In vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
5. Sperm banking.
6. Adoption.
7. Donor sperm.
8. Donor eggs.
9. Embryo and egg storage.

LAB AND PATHOLOGY

Lab and Pathology		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Lab and pathology services received in an office or other non-inpatient hospital setting	Nothing	20% coinsurance
2. Lab and pathology services received during an inpatient hospital setting	Nothing	20% coinsurance

MEDICAL-RELATED DENTAL SERVICES

Medical-related dental services are covered. Services must be received from a physician or dentist.

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a physician; b. Received during a dental procedure; and	Nothing	20% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
c. Provided to a covered person who is: i. a child under age five; ii. is severely disabled; or iii. has a condition and requires hospitalization or general anesthesia for dental care treatment		
2. For a dependent child, orthodontia, dental implants, and oral surgery treatment related to cleft lip and palate	Nothing	20% coinsurance
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury	Nothing	20% coinsurance

Medical-Related Dental Services		
Benefits	Your cost if you visit an: In-network provider, after deductible:	Out-of-network provider, after deductible:
b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.		
4. Oral surgery for: a. Partially or completely unerupted impacted teeth; b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth	Nothing	20% coinsurance

Not covered:

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

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

PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES

Physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis are covered. A physician must direct your care in order for it to be eligible for coverage.

Coverage for services provided on an inpatient basis is as described under **Hospital Services** in **Benefits & Coverage**.

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

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Physical therapy services received outside of your home		
a. Habilitative services	Nothing	20% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Rehabilitative services	Nothing	20% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing	20% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
b. Rehabilitative services	Nothing	20% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
3. Occupational therapy services received outside of your home		
a. Habilitative services	Nothing	20% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
b. Rehabilitative services	Nothing	20% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).

5. Health clubs.
6. Voice training.
7. Group physical, speech, and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

PHYSICIAN SERVICES

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

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

See **Covered Health Services** for more information.

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits **Please note:** Some services received during an office visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an office visit coinsurance and outpatient surgical or imaging coinsurance apply.	Nothing	20% coinsurance
2. Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit coinsurance and outpatient surgical coinsurance apply.	Nothing	Covered as an in-network benefit.
3. Convenience care/retail health clinic visits	Nothing	20% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
4. Virtual care	Nothing	20% coinsurance
5. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton, and nerves of the body	Nothing	20% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year.
6. Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
a. Received from a physician during an office visit, an urgent care visit, or an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance
b. Received from a physician during an inpatient stay	Nothing	20% coinsurance
7. Non-surgical services received from a physician during an inpatient stay	Nothing	20% coinsurance
8. Other outpatient hospital or ambulatory surgical center services received from a physician	Nothing	20% coinsurance
9. Hearing exams	Nothing	No coverage
10. Routine annual eye exams	Nothing. The deductible does not apply.	No coverage
11. Allergy shots	Nothing	20% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
12. Diabetes self-management training and education, including medical nutrition therapy received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	Nothing	20% coinsurance
13. Acupuncture. Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	Nothing	20% coinsurance
14. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing	20% coinsurance
15. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	Nothing	20% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
16. Treatment to lighten or remove the coloration of a port wine stain	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

Not covered:

Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection.

PREGNANCY – MATERNITY CARE

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

See **Covered Health Services** for more information.

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Outpatient prenatal services	Nothing. The deductible does not apply.	20% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Inpatient hospital stay for labor and delivery services – mother	Nothing	20% coinsurance
3. Physician services received during an inpatient stay for labor and delivery – mother	Nothing	20% coinsurance
4. Inpatient hospital stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	Nothing	20% coinsurance
5. Physician services received during an inpatient stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	Nothing	20% coinsurance
6. Labor and delivery services at a free-standing birth center		
a. Facility services for labor and delivery – mother	Nothing	20% coinsurance
b. Physician services received for labor and delivery – mother	Nothing	20% coinsurance
c. Physician services – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	Nothing	20% coinsurance

Pregnancy – Maternity Care			
	Benefits	Your cost if you visit an: In-network provider, after deductible:	Out-of-network provider, after deductible:
7.	Postnatal services	Nothing	20% coinsurance
8.	Home health care visit following delivery	Nothing	20% coinsurance

Not covered:

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

PRESCRIPTION DRUGS

Prescription drugs and supplies received from a pharmacy or a designated mail order pharmacy are covered. The coverage in the table below is your coinsurance for prescription and over-the-counter (OTC) drugs. You may experience an additional charge if you require a provider to administer self-administered drugs.

For more information about your prescription drug coverage, see **Covered Health Services**.

In this section, the phrase "covered drugs" is meant to include those prescription drugs, OTC drugs, and supplies found on the Preferred Drug List (PDL) that are prescribed by an authorized provider, unless those drugs and supplies are identified as not covered. The phrase "professionally administered drugs" means drugs that require intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs. Specialty prescription drugs are defined in **Prescription Specialty Drugs** in **Benefits & Coverage**.

Prescription unit

Supply for one prescription unit from a pharmacy: 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply)

Supply for one prescription unit from a designated mail order pharmacy: 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply)

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

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

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy, after deductible:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy, after deductible:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
1. Outpatient covered drugs other than those described below or in **Prescription Specialty Drugs** in **Benefits & Coverage**		
Tier 1: Nothing per prescription unit; or	20% coinsurance per prescription unit	**Tier 1:** Nothing per prescription unit; or
Tier 2: Nothing per prescription unit; or		**Tier 2:** Nothing per prescription unit; or
Tier 3: No coverage		**Tier 3:** No coverage
2. Infertility covered drugs. Limited to a maximum benefit of $3,000 per calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** in **Benefits & Coverage** combined.		
Tier 1: Nothing per prescription unit; or	20% coinsurance per prescription unit	**Tier 1:** Nothing per prescription unit; or
Tier 2: Nothing per prescription unit; or		**Tier 2:** Nothing per prescription unit; or
Tier 3: No coverage		**Tier 3:** No coverage
3. Diabetic equipment and supplies, including blood glucose meters		
Tier 1: Nothing per prescription unit; or	20% coinsurance per prescription unit	**Tier 1:** Nothing per prescription unit; or
Tier 2: Nothing per prescription unit; or		**Tier 2:** Nothing per prescription unit; or
Tier 3: No coverage		**Tier 3:** No coverage

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy, after deductible:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy, after deductible:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
4. All FDA-approved drugs and other supplies (including women's contraceptives), and tobacco cessation products that are considered preventive health services		
Tier 1: Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** No coverage The deductible does not apply.	20% coinsurance per prescription unit	**Tier 1:** Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** No coverage The deductible does not apply. **Please note:** Tobacco cessation products are not available through a mail order pharmacy.
5. Outpatient medications commonly used to promote and maintain healthy outcomes for certain medical conditions		
Tier 1: Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Covered the same as Tier 3 under benefit 1. in this table The deductible does not apply.	No coverage	**Tier 1:** Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Covered the same as Tier 3 under benefit 1. in this table The deductible does not apply.

Not covered:

1. Tier 3 drugs unless covered through the PDL exception process described in this plan.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (The plan will notify you before enforcement of this provision.)

3. Replacement of a drug due to loss, damage, or theft.
4. Appetite suppressants.
5. Tobacco cessation products or services dispensed through a mail order pharmacy.
6. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
7. Homeopathic medicine.
8. Specialty prescription drugs, except as described in **Prescription Specialty Drugs** in **Benefits & Coverage**.

PRESCRIPTION SPECIALTY DRUGS

Specialty prescription drugs received from a designated specialty pharmacy are covered.

Specialty prescription drugs include, but are not limited to, high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's Specialty Preferred Drug List (SPDL).

In this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs.

See **Covered Health Services** for additional important information about your specialty prescription drug coverage.

The table below describes your coinsurance for the specialty prescription drug. An additional coinsurance will apply for a provider's services if you require that they administer a self-administered drug.

<u>Prescription unit</u>

Supply for one prescription unit of a specialty prescription drug from a designated specialty pharmacy: 31-consecutive-day supply

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that are indicated on the SPDL.

Prescription Specialty Drugs	
Benefits	**You pay, after deductible**
1. Specialty prescription drugs, other than those described below, received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** Nothing per prescription unit; or **Tier 2 specialty prescription drugs:** No coverage
2. Specialty infertility prescription drugs received from a designated specialty pharmacy. Limited to a maximum benefit of $3,000 per calendar year for all infertility drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** combined.	**Tier 1 specialty prescription drugs:** Nothing per prescription unit; or **Tier 2 specialty prescription drugs:** No coverage
3. Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** Nothing per prescription unit; or **Tier 2 specialty prescription drugs:** No coverage

Not covered:

1. Tier 2 specialty prescription drugs unless covered through the SPDL exception process described in this plan.
2. Any amount above what the plan would have paid when you fail to identify yourself to the designated specialty pharmacy as a covered person. (The plan will notify you before enforcement of this provision.)
3. Replacement of a specialty drug due to loss, damage, or theft.
4. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
5. Prescription drugs, and OTC drugs, except as described in **Prescription Drugs** in **Benefits & Coverage**.
6. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.

PREVENTIVE HEALTH CARE

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

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

See **Covered Health Services** for more information.

Preventive Health Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	20% coinsurance
2. Immunizations	Nothing. The deductible does not apply.	20% coinsurance
3. Early disease detection services including physicals	Nothing. The deductible does not apply.	No coverage
4. Routine screening procedures for cancer including, but not limited to, screening for ovarian cancer and prostate cancer	Nothing. The deductible does not apply.	20% coinsurance

Preventive Health Care		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
5. Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization	Nothing. The deductible does not apply.	20% coinsurance
6. Other preventive health services	Nothing. The deductible does not apply.	20% coinsurance

RECONSTRUCTIVE AND RESTORATIVE SURGERY

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

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

Not covered:

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

SKILLED NURSING FACILITY

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

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

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

Skilled Nursing Facility			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per person per calendar year for in-network and out-of-network services combined	Nothing	20% coinsurance
2.	Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered	Nothing	20% coinsurance
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing	20% coinsurance

Not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.

9. Group physical, speech, and occupational therapy.
10. Long-term care.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

TRANSPLANT SERVICES

See **Covered Health Services** for more information.

Transplant Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Organ and bone marrow transplant services **Prior authorization is required for all transplant services.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Supplies and services related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by the plan under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial, or non-human organ implants or transplants and related services that would not be authorized by the plan under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**,

Prescription Specialty Drugs, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

WEIGHT LOSS SURGERY

Coverage for surgery for morbid obesity is provided. Services must be provided under the direction of a designated network physician and received at a designated network facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

See **Covered Health Services** for more information.

Weight Loss Surgery			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Weight loss surgery services	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage

Not covered:

1. Surgery for morbid obesity when performed by a network physician that is not a designated physician or received at a network facility that is not a designated facility.
2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by the plan.

6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

X-RAY AND OTHER IMAGING

X-Ray and Other Imaging			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	X-rays and other imaging services received in a non-inpatient setting	Nothing	20% coinsurance
2.	MRI, CT, and PET CT scans	Nothing	20% coinsurance
3.	X-rays and other imaging services received in an inpatient setting	Nothing	20% coinsurance

Covered Health Services

This section describes services covered on this plan. The **Benefits & Coverage** section provides coverage specifics and what you would pay for each service.

Ambulance services

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, emergency health services at that hospital are covered.

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

Behavioral health – mental health

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

Outpatient mental disorder services include:

- Diagnostic evaluations and psychological testing.
- Psychotherapy and psychiatric services.
- Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Treatment for a minor, including family therapy.
- Treatment of serious or persistent disorders.
- Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Treatment of pathological gambling.
- Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional.

Inpatient mental disorder services include:

- Room and board.
- Attending psychiatric services.
- Hospital or facility-based professional services.
- Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and

supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.

- Services, care, or treatment described as benefits in this plan and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- Residential treatment services. These services include either:
  - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
  - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

The plan's designated mental health provider will arrange your in-network mental health benefits. If you require hospitalization, the plan's designated mental health provider will refer you to one of its hospital providers. (The plan and the designated mental health provider hospital networks are different.)

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

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

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

Behavioral health – substance abuse

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

Outpatient substance abuse services include:

- Diagnostic evaluations.
- Outpatient treatment.
- Intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

Inpatient substance abuse services include:

- Room and board.
- Attending physician services.
- Hospital or facility-based professional services.
- Services, care, or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.
- Residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours (15 hours for children and adolescents) per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

The plan's designated substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, the plan's designated substance abuse provider will refer you to one of its hospital providers. (The plan and the designated substance abuse provider hospital networks are different.)

In-network benefits will apply to services, care or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by any applicable Department of Corrections.

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

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

- Psychiatrist
- Psychologist

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

Durable medical equipment, prosthetics, and medical supplies

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

The plan periodically reviews and modifies the list of eligible durable medical equipment and certain related supplies. To request the most up-to-date list, call Customer Service at one of the telephone numbers listed inside the front cover.

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

In-network benefits apply when eligible equipment, services, and supplies are prescribed by a physician and received from a network provider. Hearing aids are covered as described in **Benefits & Coverage**, when prescribed by a network provider.

To request a list of durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.

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

Emergency room care

Emergency services from non-network providers will be covered as in-network benefits. If you receive scheduled or follow-up care after an emergency, services must be received from a network provider in order for you to receive in-network benefits.

Home health care

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

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

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

If you are a ventilator-dependent patient with communication needs, and you require private duty nurse or personal care assistant home care services in your home, the plan will cover up to 120 hours of communication training to assure adequate communication with hospital staff.

Hospice services

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

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

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

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

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

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

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

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

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

Infertility treatment

The diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child is covered. Coverage includes benefits for professional, hospital, and ambulatory surgical center services. Infertility treatment must be received from or under the direction of a physician. See **Benefits & Coverage – Prescription Drugs** for coverage of infertility drugs.

Medical-related dental services

Medically necessary outpatient dental services are covered. Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this plan. See **Benefits & Coverage** for specific services that are covered or excluded.

Newborn coverage

Your dependent newborn is covered from birth. The plan does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one of the telephone numbers listed inside the front cover for more information. If additional premium is required, the plan is entitled to all premiums due from the time of the infant's birth until the time you notify the plan of the birth. The plan may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see **Eligibility and Enrollment**.

Pregnancy – maternity care

Benefits for your pregnancy care include medical services for prenatal care, labor and delivery, postnatal care, and related complications.

<u>Prenatal care</u>

Prenatal services include:

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

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

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

- Conditions that have arisen concurrently with the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or skin rash.
- Miscarriage and ectopic pregnancy.

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this plan. Please refer to those sections for coverage information.

Labor and delivery

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

Postnatal care

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

One home health care visit is covered if it occurs within 4 days of discharge. If services are received after 4 days, please refer to **Home Health Care** in **Benefits & Coverage** for benefits.

Newborns' and Mothers' Health Protection Act of 1996

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

For benefits and the amounts you pay, see **Benefits & Coverage**. Each covered person's admission is separate from the admission of any other covered person. A separate deductible and coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery. **Please note:** We encourage you to enroll your newborn dependent under the plan within 30 days from the date of birth, date of placement for adoption, or date of adoption. Please refer to **Eligibility and Enrollment** for additional information.

Physician services

In-network benefits apply to:

- Professional services received from a network provider;
- Emergency services from non-network providers will be covered as in-network benefits.

Post-mastectomy coverage

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

Prescription drugs

Preferred Drug List (PDL)

Medica's PDL identifies whether a drug is classified by Medica as a Tier 1, Tier 2, or Tier 3 covered drug. In general, only drugs on Medica's PDL are eligible for coverage.

The PDL is grouped into the following tiers:

Tier 1 is your lowest coinsurance option. For the lowest out-of-pocket expense, you should consider a Tier 1 covered drug if you and your physician decide it is appropriate for your treatment.

Tier 2 is your higher coinsurance option. You may consider a Tier 2 covered drug to treat your condition if you and your physician decide it is appropriate.

Tier 3 drugs are not covered unless they meet the requirements under the PDL exception process described in this plan.

If you have questions about Medica's PDL or whether a specific drug is covered (and/or the PDL tier in which the drug may be covered), or if you would like to request a copy of the PDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The PDL is also available when you sign in at mymedica.com.

Medica selects drugs for the PDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a drug on the PDL, and the tier to which a drug is assigned, are based on the drug's safety, efficacy, uniqueness, and cost.

Exceptions to the PDL

If your physician thinks a non-covered drug is medically necessary, he/she may request an exception. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** In the event Medica grants an exception, coverage will be provided at the Tier 2 benefit level. In certain circumstances, your physician may request that Medica make an exception to the coverage rules described under Preferred Drug List (PDL) above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one tier. Exceptions to the PDL can also include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the PDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to

Medica that the health care provider has considered all equivalent drugs in the health plan's PDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's PDL for safety reasons. Medica will grant an exception to the PDL if the patient's health care provider indicates to us that any of the following apply: (a) the PDL drug causes an adverse reaction in the patient; (b) the PDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's PDL for safety reasons. If you would like to request a copy of Medica's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain covered drugs require prior authorization, as indicated on the PDL. The network provider who prescribes the drug initiates prior authorization. The PDL is made available to providers, including pharmacies and the designated mail order pharmacies. You are responsible for paying the cost of drugs received if you do not meet the plan's authorization criteria.

Step therapy

The plan requires a step therapy process prior to coverage of certain drugs, as indicated on the PDL. Step therapy involves trying an alternative covered drug first (typically a Tier 1 drug) before moving to a Tier 2 or Tier 3 covered drug for treatment of the same medical condition. Applicable step therapy requirements and PDL exception process requirements must be met before Medica will cover Tier 2 or Tier 3 covered drugs.

Quantity limits

Certain covered drugs are assigned quantity limits, as indicated on the PDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Mail order pharmacy benefits

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

Diabetic equipment and supplies (excluding blood glucose meters) are available via mail order if received from a designated mail order pharmacy.

Preventive drugs and other services, as specifically defined in **Definitions**, are eligible for mail order coverage. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service. **Note: Tobacco cessation products are not available through mail order.**

Retail pharmacy benefits

Retail pharmacy benefits include, but are not limited to:

- Preventive drugs and other services, as specifically defined in **Definitions**. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service.
- Diabetic equipment and supplies, including blood glucose meters.
- Tobacco cessation products prescribed by a provider authorized to prescribe the product.
- Insulin pumps, as covered under **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.

See **Prescription Specialty Drugs** in **Benefits & Coverage** for growth hormone and other specialty prescription drug coverage information.

Prescription specialty drugs

Designated specialty pharmacies

A designated specialty pharmacy means a specialty pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to covered persons. For the current list of designated specialty pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com.

Specialty Preferred Drug List (SPDL)

Medica has a tiered SPDL that identifies specialty prescription drugs that are covered, unless they are otherwise listed as not covered in this plan. The SPDL also identifies whether a drug is classified by Medica as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on Medica's SPDL are eligible for benefits under this plan.

Tier 2 specialty prescription drugs are not covered unless they meet the requirements under the SPDL exception process described in this plan. The applicable coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefits table in **Prescription Specialty Drugs** in **Benefits & Coverage**.

If you have questions about Medica's SPDL or whether a specific specialty prescription drug is covered (and/or the SPDL tier in which the drug may be covered), or if you would like to request a copy of the SPDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The SPDL is also available by signing in at mymedica.com.

Medica selects specialty drugs for the SPDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a specialty drug on the SPDL, and the tier to which a specialty drug is assigned, are based on the specialty drug's safety, efficacy, uniqueness, and cost.

Exceptions to the SPDL

If your physician thinks a non-covered specialty drug is medically necessary, he/she may request an exception. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** In the event Medica grants an exception, coverage will be provided at the Tier 2 specialty prescription drug benefit level. In certain circumstances your physician may request that Medica make an exception to the coverage rules described under Specialty Preferred Drug List (SPDL) above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one tier. Exceptions to the SPDL can also include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the SPDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's SPDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's SPDL for safety reasons. Medica will grant an exception to the SPDL if the patient's health care provider indicates to us that any of the following apply: (a) the SPDL drug causes an adverse reaction in the patient; (b) the SPDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's SPDL for safety reasons. If you would like to request a copy of Medica's SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain specialty prescription drugs require prior authorization from Medica. The network provider who prescribes the specialty drug initiates prior authorization. The SPDL is made available to providers, including designated specialty pharmacies. You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria.

Step therapy

The plan requires step therapy prior to coverage of specific specialty prescription drugs as indicated on the SPDL. Step therapy involves trying an alternative covered specialty prescription drug (typically a Tier 1 specialty prescription drug) before moving to certain other Tier 1 or Tier 2 specialty prescription drugs for treatment of the same medical condition. Applicable step therapy requirements and SPDL exception process requirements must be met before the plan will cover certain Tier 1 or Tier 2 specialty prescription drugs.

Quantity limits

Certain specialty prescription drugs are assigned quantity limits as indicated on the SPDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Transplant services – organ and bone marrow

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

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

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

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

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

In-network benefits apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a hospital that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities.

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

There is no coverage for out-of-network benefits.

Weight loss surgery

In-network benefits apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or designated facility is a network physician or hospital that has been designated by Medica to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

There is no coverage for out-of-network benefits.

Exclusions

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

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

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

16. Custodial care, unskilled nursing, or unskilled rehabilitation services.
17. Respite or rest care, except as otherwise covered in **Hospice Services** in **Benefits & Coverage**.
18. Travel, transportation, or living expenses.
19. Household equipment, fixtures, home modifications, and vehicle modifications.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies, and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and amyotrophic lateral sclerosis.
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability, or any similar law.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by the plan, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **Benefits & Coverage**.
30. Dental prostheses.
31. Any orthodontia, except as described in **Medical-Related Dental Services** in **Benefits & Coverage** for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
34. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
35. Exams, other evaluations, or other services received solely for the purpose of employment, insurance, or licensure.
36. Exams, other evaluations, or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities unless otherwise covered under this plan.
37. Non-medical self-care or self-help training.

38. Educational classes, programs, or seminars, including but not limited to childbirth classes, except as described in **Physician Services** in **Benefits & Coverage**.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this plan.
42. Orthognathic surgery for cosmetic purposes.
43. Services for sex transformation operations.
44. Sensory integration, including auditory integration training.
45. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician Services** in **Benefits & Coverage**.
46. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders for covered persons 18 years of age and older. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
47. Health care professional services for home labor and delivery.
48. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
49. Services solely for or related to the treatment of snoring.
50. Interpreter services, except as described in **Home Health Care** in **Benefits & Coverage**.
51. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
52. Services for private duty nursing, except as described in **Home Health Care** in **Benefits & Coverage**. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the covered person or the covered person's representative, and not under the direction of a physician.
53. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
54. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
55. Health clubs.
56. Long-term care.
57. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements, or publications.

58. Any charges for mailing, interest, and delivery, such as the cost for mailing medical records.

Role of Medica

The plan administrator has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica's responsibilities generally consist of determining the validity of claims pursuant to the terms of the plan and administering benefit payments under this plan and determining the resolution of complaints and appeals pursuant to the terms of **Complaints**. The service agreement between the plan administrator and Medica is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. Medica is a third party retained by the plan administrator. Medica is not a COBRA administrator. The plan offers Medica Choice Passport.

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

This section describes how providers are generally paid for health services. See **Definitions** at the end of this document for defined terms and phrases.

Network providers

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

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

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

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

Risk-sharing payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per covered person, or an amount

per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a covered person's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a covered person's health services, the network provider may keep some of the excess.

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

Withhold arrangements

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

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

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

Harmful Use of Medical Services

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

When this section applies

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

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

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

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

Medica will send you specific information about:

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

How to Submit a Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

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

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

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

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

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

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

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

Claims for services provided outside the United States

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

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

- Such other documentation as the plan may request.

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

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

Time limits

If you have a complaint or disagree with a decision by the plan, you may follow the complaint procedure outlined in **Complaints**.

Coordination of Benefits

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

Applicability

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

Definitions that apply to this section

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

   Each contract or other arrangement for coverage under a. or b. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
2. This plan is the part of the plan that provides benefits for health care expenses.
3. *Primary plan/secondary plan.* The **Order of benefit determination rules** state whether this plan is a primary plan or secondary plan as to another plan covering the person.

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

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

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

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

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

   The difference between the charges billed by a provider and the non-network provider reimbursement amount is not considered an allowable expense under the above definition.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

   When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, and preferred provider arrangements.

5. Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of benefit determination rules

1. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

   a. The other plan has rules coordinating its benefits with the rules of this plan; and

   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.

2. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

   a. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, covered person, or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

b. *Dependent child/parents not separated or divorced*. Except as stated in c. below, when this plan and another plan cover the same child as a dependent of different persons, called “parents”:

   i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   ii. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in 2.b.i. immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   i. First, the plan of the parent with custody of the child;

   ii. Then, the plan of the spouse of the parent with the custody of the child; and

   iii. Finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. *Joint custody*. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the **Order of benefit determination rules** outlined in 2.b.

e. *Active/inactive employee*. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. *Workers’ compensation*. Coverage under any workers’ compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer, before submitting them to the plan.

g. *No-fault automobile insurance*. Coverage under the No-Fault Automobile Insurance Act or similar law applies first.

h. *Longer/shorter length of coverage*. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, covered person, or enrollee longer are determined before those of the plan which covered that person for the shorter term.

Effect on the benefits of this plan

1. *When this section applies*. This section applies when, in accordance with **Order of benefit determination rules**, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in 2. immediately below.

2. *Reduction in this plan's benefits*. The benefits of this plan will be reduced when the sum of:

   a. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

   b. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

   For non-emergency services received from a non-network provider, and determined to be out-of-network benefits, the following reduction of benefits will apply:

   When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under the plan, according to the out-of-network benefits described. Most out-of-network benefits are covered at 80 percent of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

   When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. The plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The plan need not tell, or get the consent of, any person to do this. Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under this plan must give the plan any facts it needs to pay the claim.

Facility of payment

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, the plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The plan will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by the plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid; or
2. Insurance companies; or
3. Other organizations.

The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

Please note: See **Right of Recovery** for additional information.

Right of Recovery

This section describes this plan's right of recovery. This plan's rights may be subject to Minnesota and federal law. For information about the effect of applicable state and federal law on this plan's subrogation rights, contact an attorney.

See **Definitions** at the end of this document for defined terms and phrases.

1. This plan has a right of subrogation against any third party, individual, corporation, insurer, or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. This plan's right of subrogation shall be governed according to this section. This plan's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. This plan's subrogation interest is the reasonable cash value of any benefits received by you.
3. This plan's right to recover its subrogation interest may be subject to an obligation by the plan to pay a pro rata share of your disbursements, attorney fees, and costs you pay in obtaining your recovery.
4. By accepting coverage under the plan, you agree:
    a. To cooperate with the plan administrator, sponsor, or plan designee to help protect the plan's legal rights under this subrogation provision and to provide all information the plan may reasonably request to determine its rights under this provision.
    b. To provide prompt written notice to the plan administrator when you make a claim against a party for injuries.
    c. To provide prompt written notice of the plan's subrogation rights to any party against whom you assert a claim for injuries.
    d. To do nothing to decrease the plan's rights under this provision, either before or after receiving benefits.
    e. The plan may take action to preserve its legal rights. This includes bringing suit in your name.
    f. The plan may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative, or the legal representative(s) of your estate or next-of-kin.
    g. To hold in trust the proceeds of any settlement or judgment for the plan's benefit under this provision.

Eligibility and Enrollment

This section describes who can enroll and how to enroll.

Who can enroll

All qualified employees and dependents as defined in **Definitions** are eligible for coverage under this plan. In order for an eligible dependent to enroll in the plan, the qualified employee must also be enrolled.

How to enroll

Submit an application for coverage for the qualified employee and/or any dependents to the plan administrator:

1. During the initial enrollment period as described in this section under **Initial enrollment and effective date of coverage**; or
2. During the open enrollment period as described in this section under **Open enrollment and effective date of coverage**; or
3. During a special enrollment period as described in this section under **Special enrollment and effective date of coverage**; or
4. At any other time as a late enrollee as described in this section under **Late enrollment and effective date of coverage**.

Dependents will not be enrolled without the qualified employee also being enrolled. A child who is the subject of a medical support order can be enrolled as described in this section under **Medical Support Order** and under **Special enrollment and effective date of coverage**.

Initial enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and/or any dependents to the plan administrator during the initial enrollment period, which will be communicated to the qualified employee by the plan administrator.

A covered person who is a child entitled to receive coverage through a medical support order is not subject to any initial enrollment period restrictions, except as noted in this section.

Your coverage begins at 12:01 a.m. on the effective date of your enrollment.

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the first of the month following 30 days (one month) of employment.

Open enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and any dependents to the plan administrator during the open enrollment period, which will be communicated to the qualified employee by the plan administrator. Open enrollment period means the period of time occurring toward the end of the calendar year during which qualified employees and eligible dependents who are not covered under the plan may elect to begin coverage effective the first day of the upcoming calendar year.

Your coverage begins at 12:01 a.m. on the effective date of your coverage.

For qualified employees and dependents who enroll during the open enrollment period, coverage begins on the first day of the calendar year for which the open enrollment period was held.

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified employees and dependents under certain circumstances. Qualified employees and dependents who are eligible to enroll during a special enrollment period may enroll in any medical benefit package or option available to similarly situated individuals who enroll when first eligible. **However, all other provisions of the plan, including but not limited to provisions setting a lifetime maximum on benefits, will apply to special enrollees.**

1. Loss of other coverage

    a. A special enrollment period will apply to a qualified employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The qualified employee or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

    In the case of the qualified employee's loss of coverage, this special enrollment period applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of coverage, this special enrollment period applies to both the dependent who has lost coverage and the qualified employee.

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under creditable coverage other than Medicaid or a State Children's Health Insurance Plan at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment, and declined coverage for that reason.

    The qualified employee or dependent must present to the plan administrator either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated, and

request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

i. Prior coverage does not include federal or state continuation coverage;

ii. Loss of eligibility includes:

- loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
- cessation of dependent status;
- incurring a claim that causes the qualified employee or dependent to meet or exceed the lifetime maximum limit on all benefits;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the qualified employee or dependent.

iii. Loss of eligibility occurs regardless of whether the qualified employee or dependent is eligible for or elects applicable federal or state continuation coverage;

iv. Loss of eligibility does not include a loss due to failure of the qualified employee or dependent to pay premiums on a timely basis or termination of coverage for cause;

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent that has lost coverage and the qualified employee; dependents will not be enrolled without the qualified employee also being enrolled.

c. A special enrollment period will apply to a qualified employee and dependent if the eligible employee or dependent was covered under benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or any applicable state continuation laws at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment and declined coverage for that reason.

The qualified employee or dependent must present to the plan administrator evidence that the qualified employee or dependent has exhausted such COBRA or

state continuation coverage and has not lost such coverage due to failure of the qualified employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 30 days of the date of the exhaustion of coverage.

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
- losing coverage as a result of the employer's failure to remit premiums on a timely basis; or
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

ii. Exhaustion of COBRA or state continuation coverage does not include a loss due to failure of the qualified employee or dependent to pay premiums on a timely basis or termination of coverage for cause;

iii. In the case of the qualified employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee; dependents will not be enrolled without the qualified employee also being enrolled.

2. The dependent is a new spouse of the enrollee or qualified employee, provided that the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided that the qualified employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided that enrollment is requested in writing within 30 days of the enrollee or qualified employee acquiring the dependent and provided that the qualified employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption, or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the enrollee acquires the dependent child.

4. The dependent is the spouse of the enrollee or qualified employee through whom the dependent child described in 3. above claims dependent status and:
   a. That spouse is eligible for coverage; and
   b. Is not already enrolled under the plan; and
   c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and
   d. The qualified employee also enrolls during this special enrollment period; and

   Coverage is effective on the date coverage for the dependent child is effective, as set forth in 3. above.
5. The dependents are eligible dependent children of the enrollee or qualified employee and enrollment is requested in writing within 30 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the qualified employee also enrolls during this special enrollment period. Coverage is effective on the date coverage for the dependent is effective, as set forth in 2. or 3. above (as applicable).
6. When the employer is provided with notice of a medical support order and a copy of the order, as described in this section, the employer will provide the eligible dependent child with a special enrollment period provided the qualified employee also enrolls during this special enrollment period. Coverage is effective the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator. Any child who is a covered person pursuant to a medical support order will be covered without application of waiting periods.

Late enrollment and effective date of coverage

The plan allows enrollment as a late enrollee for qualified employees and eligible dependents enrolling outside of the initial enrollment period, the open enrollment period, or any special enrollment period described in this section.

Your coverage begins at 12:01 a.m. on the effective date of your coverage.

Coverage will be effective the first day of the month following the date of the plan administrator's approval of the request for enrollment.

Medical Support Order

The plan is intended to comply with the requirements of applicable Minnesota law regarding medical support orders. This may result in the delay of a termination of coverage as described in **Ending Coverage**. Notwithstanding any provision of this plan to the contrary, this plan shall recognize support orders that address medical coverage for dependent children and former spouses in accordance with the requirements under Section 518A.41 of the Minnesota Statutes as determined by the plan administrator according to its policy relating to the plan established for the purpose of complying with these requirements.

Ending Coverage

This section describes when coverage ends under the plan. When this happens you may exercise your right to continue your coverage as described in **Continuation**.

When your coverage ends

Unless otherwise specified, coverage ends the earliest of the following:

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The end of the month for which the enrollee or covered person last paid any required contribution to the plan.
3. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. See **Eligibility and Enrollment** for information on eligibility.
4. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
5. The end of the month following the date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
6. The date specified by the plan administrator because a covered person permitted the use of his or her identification card by any unauthorized person or used another person's card or submitted fraudulent claims.
7. The end of the month in which a covered person enters active military duty for more than 31 days. Upon completion of active military duty, contact the plan administrator to discuss reinstatement of coverage.
8. The date specified by the plan administrator in written notice to a covered person that coverage ended due to the plan administrator's determination that the covered person committed fraud in applying for this coverage or for any of its benefits. Fraud includes, but is not limited to, intentionally providing the plan administrator with false material information such as:

   a. Information related to an enrollee's eligibility or another person's eligibility for coverage or status as a dependent; or

   b. Information related to an enrollee's health status or that of any dependent; or

   c. Intentional misrepresentation of the employer-employee relationship.

   Coverage will be retroactively terminated at the plan administrator's discretion to the original date of coverage or the date on which the fraudulent act took place. No continuation privilege will be extended.

Continuation

Required continuation coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under state law, federal law, or both. All aspects of continuation coverage administration are the responsibility of the plan administrator.

Additionally, when you lose group health coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You and your family may have coverage options through the Exchange, Medicaid, or other group health plan coverage options (such as a spouse's plan). For example, you may be eligible to buy an individual or family plan through the Exchange. By enrolling in coverage through the Exchange, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

The paragraph below describes the continuation coverage provisions. State continuation is described in **Your right to continue coverage under state law** and federal continuation is described in **Your right to continue coverage under federal law**.

If your coverage ends, you should review your rights under both state law and federal law with the plan administrator. If you are entitled to continuation rights under both, the continuation provisions run concurrently and the more favorable continuation provision will apply to your coverage.

Your right to continue coverage under state law

Notwithstanding the provisions regarding termination of coverage described in **Ending Coverage**, you may be entitled to extended or continued coverage as follows:

1. **Minnesota state continuation coverage.**

   Continued coverage shall be provided as required under applicable Minnesota law. Minnesota state continuation requirements apply to all group health plans that are subject to state regulation, regardless of the number of employees in the group. The plan administrator shall, within the parameters of Minnesota law, establish uniform policies pursuant to which such continuation coverage will be provided.

2. **Notice of rights.**

   Minnesota law requires that covered employees and their dependents (spouse and/or dependent children) be offered the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end.

This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of Minnesota law. It is intended that no greater rights be provided than those required by Minnesota law. Take time to read this section carefully.

Enrollee's loss

The enrollee has the right to continuation of coverage for him or herself and his or her dependents if there is a loss of coverage under the plan because of the enrollee's voluntary or involuntary termination of employment (for any reason other than gross misconduct) or layoff from employment. In this section, layoff from employment means a reduction in hours to the point where the enrollee is no longer eligible for coverage under the plan.

Enrollee's spouse's loss

The enrollee's covered spouse has the right to continuation coverage if he or she loses coverage under the plan for any of the following reasons:

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. Dissolution of marriage from the enrollee;
4. The enrollee's enrollment for benefits under Medicare.

Enrollee's child's loss

The enrollee's dependent child has the right to continuation coverage if coverage under the plan is lost for any of the following reasons:

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. Termination of the enrollee's employment (for any reason other than gross misconduct) or layoff from employment;
3. The enrollee's dissolution of marriage from the child's other parent;
4. The enrollee's enrollment for benefits under Medicare if the enrollee is the parent through whom the child receives coverage;
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

Under Minnesota law, the enrollee and dependents have the responsibility to inform the plan administrator of a dissolution of marriage or a child losing dependent status under the plan within 60 days of the date of the event or the date on which coverage would be lost because of the event.

Election rights

When the plan administrator is notified that one of these events has happened, the enrollee and the enrollee's dependents will be notified of the right to continuation coverage.

Consistent with Minnesota law, the enrollee and dependents have 60 days to elect continuation coverage for reasons of termination of the enrollee's employment or the enrollee's enrollment for benefits under Medicare measured from the later of:

1. The date coverage would be lost because of one of the events described above; or
2. The date notice of election rights is received.

If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. Under certain circumstances, the enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

If continuation coverage is not elected, your coverage under the plan will end.

Type of coverage and cost

If continuation coverage is elected, the enrollee's sponsor is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or employees' dependents.

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the sponsor of all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage.

Surviving dependents of a deceased enrollee have 90 days after notice of the requirement to pay continuation premiums to make the first payment.

Duration

Under the circumstances described above and for a certain period of time, Minnesota law requires that the enrollee and his or her dependents be allowed to maintain continuation coverage as follows:

1. For instances where coverage is lost due to the enrollee's termination of or layoff from employment, coverage may be continued until the earliest of:
    a. 18 months after the date of the termination of or layoff from employment;
    b. The date the enrollee becomes covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
    c. The date coverage would otherwise terminate under the plan.

2. For instances where the enrollee's spouse or dependent children lose coverage because of the enrollee's enrollment under Medicare, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under another group health plan; or
    c. The date coverage would otherwise terminate under the plan.
3. For instances where dependent children lose coverage as a result of loss of dependent eligibility, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under another group health plan; or
    c. The date coverage would otherwise terminate under the plan.
4. For instances of dissolution of marriage from the enrollee, coverage of the enrollee's spouse and dependent children may be continued until the earliest of:
    a. The date the former spouse becomes covered under another group health plan; or
    b. The date coverage would otherwise terminate under the plan.

    If a dissolution of marriage occurs during the period of time when the enrollee s spouse is continuing coverage due to the enrollee's termination of or layoff from employment, coverage of the enrollee's spouse may be continued until the earlier of:
    a. The date the former spouse becomes covered under another group health plan; or
    b. The date coverage would otherwise terminate under the plan.
5. If coverage is lost because of the enrollee's absence from work due to total disability, coverage of the enrollee and any dependents may be continued until the date coverage would otherwise terminate under the plan.
6. Upon the death of the enrollee, the coverage of a enrollee's spouse or dependent children may be continued until the earlier of:
    a. The date the surviving spouse and dependent children become covered under another group health plan; or
    b. The date coverage would have terminated under the plan had the enrollee lived.

Extension of benefits for total disability of the enrollee

Coverage may be extended for a enrollee and his or her dependents in instances where the enrollee is absent from work due to total disability, as defined in **Definitions**. If the enrollee is required to pay all or part of the premium for the extension of coverage, payment shall be made to the sponsor. The amount charged cannot exceed 100 percent of the cost of the coverage.

Your right to continue coverage under federal law

Notwithstanding the provisions regarding termination of coverage described in **Ending Coverage**, you may be entitled to extended or continued coverage as follows:

COBRA continuation coverage

Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended as it applies to state governmental entities through the Public Health Service Act (PHSA), as amended. The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General COBRA information in this section. In addition, continuation of coverage requirements under Minnesota law shall be followed as described in this section.

USERRA continuation coverage

Continued coverage shall be provided as required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General USERRA information in this section.

General COBRA information

COBRA, as it applies to state governmental entities through the PHSA, requires employers with 20 or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for purposes of COBRA.

This section is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of federal law. It is intended that no greater rights be provided than those required by federal law. Take time to read this section carefully.

Qualified beneficiary

For purposes of this section, a qualified beneficiary is defined as:

1. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);
2. A covered spouse of a covered employee; or
3. A dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Enrollee's loss

The enrollee has the right to elect continuation of coverage if there is a loss of coverage under the plan because of termination of the enrollee's employment (for any reason other than gross misconduct), or the enrollee becomes ineligible to participate under the terms of the plan due to a reduction in his or her hours of employment.

Enrollee's spouse's loss

The enrollee's covered spouse has the right to choose continuation coverage if he or she loses coverage under the plan for any of the following reasons:

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. Divorce or legal separation from the enrollee; or
4. The enrollee's entitlement to (actual coverage under) Medicare.

Enrollee's child's loss

The enrollee's dependent child has the right to continuation coverage if coverage under the plan is lost for any of the following reasons:

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. The enrollee's termination of employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. The enrollee's divorce or legal separation from the child's other parent;
4. The enrollee's entitlement to (actual coverage under) Medicare if the enrollee is the parent through whom the child receives coverage; or
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

Under the law, the enrollee and dependent have the responsibility to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the date of the event, or the date on which coverage would be lost because of the event.

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator of that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the plan administrator within 30 days of the determination.

Bankruptcy

Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees) if the enrollee's employer commences a bankruptcy proceeding and these individuals lose coverage.

Election rights

When notified that one of these events has happened, the plan administrator will notify the enrollee and dependents of the right to choose continuation coverage.

Consistent with federal law, the enrollee and dependents have 60 days to elect continuation coverage, measured from the later of:

1. The date coverage would be lost because of one of the events described above, or
2. The date notice of election rights is received.

If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other covered dependents entitled to continuation coverage. However, each person entitled to continuation coverage has an independent right to elect continuation coverage. The enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

If continuation coverage is not elected, your coverage under the plan will end.

Type of coverage and cost

If the enrollee and the enrollee's dependents elect continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or employees' dependents.

Under federal law, a person electing continuation coverage may have to pay all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage. The amount may be increased to 150 percent of the applicable premium for months after the 18th month of continuation coverage when the additional months are due to a disability under the Social Security Act.

There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the plan because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended if a second event (e.g., divorce, legal separation, or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's covered dependent who is determined to be disabled under the Social Security Act at the time of

the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period.

If an employee or the employee's covered dependent is entitled to 29 months of continuation coverage due to his or her disability, the other family members' continuation period is also extended to 29 months. If the enrollee becomes entitled to (actually covered under) Medicare, the continuation period for the enrollee's dependents is 36 months measured from the date of the enrollee's Medicare entitlement even if that entitlement does not cause the enrollee to lose coverage.

Under no circumstances is the total continuation period greater than 36 months from the date of the original event that triggered the continuation coverage.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

1. The enrollee's employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
4. The enrollee becomes entitled to (actually covered under) Medicare.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

General USERRA information

USERRA requires employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for the purposes of USERRA.

This section is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of federal law. It is intended that no greater rights be provided than those required by federal law. Take time to read this section carefully.

Employee's loss

The employee has the right to elect continuation of coverage if there is a loss of coverage under the plan because of absence from employment due to service in the uniformed services, and the employee was covered under the plan at the time the absence began, and the employee, or an appropriate officer of the uniformed services, provided the employer with advance notice of the employee's absence from employment (if it was possible to do so).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and the

time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Uniformed services means the U.S. Armed Services, including the Coast Guard, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, and the commissioned corps of the Public Health Service.

Election rights

The employee or the employee's authorized representative may elect to continue the employee's coverage under the plan by making an election on a form provided by the plan administrator. The employee has 60 days to elect continuation coverage measured from the date coverage would be lost because of the event described above. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost. The employee may elect continuation coverage on behalf of other covered dependents, however, there is no independent right of each covered dependent to elect. If the employee does not elect, there is no USERRA continuation available for the spouse or dependent children. In addition, even if the employee does not elect USERRA continuation, the employee has the right to be reinstated under the plan upon reemployment, subject to the terms and conditions of the plan.

Type of coverage and cost

If the employee elects continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees. The amount charged cannot exceed 102 percent of the cost of the coverage unless the employee's leave of absence is less than 31 days, in which case the employee is not required to pay more than the amount that they would have to pay as an active employee for that coverage. There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of USERRA coverage

When an employee takes a leave for service in the uniformed services, coverage for the employee and dependents for which coverage is elected begins the day after the employee would lose coverage under the plan. Coverage continues for up to 24 months.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

1. The employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;
4. The employee fails to return to work following the completion of his or her service in the uniformed services; or
5. The employee returns to work and is reinstated under the plan as an active employee.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

COBRA and USERRA coverage are concurrent

If the employer is subject to both COBRA and USERRA, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

Other continuation coverage

Notwithstanding the provisions regarding termination of coverage described in **Ending Coverage**, you may be entitled to extended or continued coverage as follows:

Retiree coverage

Retiree coverage shall be provided in accordance with Section 471.61 of the Minnesota Statutes for a retiree and his or her dependents enrolled under the plan immediately preceding the enrollee's retirement. Sponsor may pay a portion of the premium for such coverage. Eligibility with respect to the availability of continuation coverage beyond the requirements of Minnesota Statutes Section 471.61 shall be determined by sponsor, pursuant to its Policy and Procedure. The retiree coverage may run concurrently with any available COBRA or state continuation coverage or the retiree coverage may be offered in lieu of the COBRA or state continuation coverage.

Surviving spouse

The surviving spouse (widow or widower) of a qualified employee or a retiree will remain eligible for coverage under this plan if:

1. Both the spouse and the qualified employee or retiree were covered persons under the plan at the time of the qualified employee's or retiree's death; and
2. The surviving spouse remains unmarried.

The sponsor may pay a portion of the premium for such coverage. Any available COBRA or state continuation coverage may run concurrently with surviving spouse coverage.

Leaves of absence

An enrollee on a leave of absence from employment with the sponsor and that is approved by the sponsor may be entitled to continuation coverage. The sponsor may pay a portion of the premium for such coverage. Eligibility, as it pertains to the availability of continuation coverage during a leave of absence, shall be determined by the sponsor, in accordance with its leave of absence policy. Any available COBRA or state continuation coverage may run concurrently with leave of absence coverage.

Insurability

A person does not have to demonstrate insurability to elect continuation coverage. At the end of the 18, 24, 29, or 36-month continuation period, as applicable, there is no opportunity to enroll in an individual conversion health plan.

Complaints

This section describes what to do if you have a complaint or would like to appeal a decision made by the plan.

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in **First level of review**. You may also contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 539-1600 or 1-800-657-3602.

Filing a complaint may require that Medica review your medical records as needed to resolve your complaint.

You may appoint an authorized representative to make a complaint on your behalf. You may be required to sign an authorization which will allow Medica to release confidential information to your authorized representative and allow them to act on your behalf during the complaint process.

Upon request, Medica will assist you with completion and submission of your written complaint. Medica will also complete a complaint form on your behalf and mail it to you for your signature upon request.

At any time during the complaint process, you have a right to submit any information or testimony that you want Medica to consider and to review any information that Medica relied on in making its decision.

In addition to directing complaints to Customer Service as described in this section, you may direct complaints at any time to the Commissioner of Commerce at the telephone number listed at the beginning of this section.

First level of review

You may direct any question or complaint to Customer Service by calling one of the telephone numbers listed inside the front cover or by writing to the address listed below.

Complaints that do not involve a medical necessity review by Medica:

1. For an oral complaint, if Medica does not communicate a decision within 10 business days from Medica's receipt of the complaint, or if you determine that Medica's decision is partially or wholly adverse to you, Medica will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

   Customer Service
   Route 0501
   PO Box 9310
   Minneapolis, MN 55440-9310

   Medica will provide written notice of its first level of review decision to you within 30 days from the initial receipt of your complaint.

2. For a written complaint, Medica will provide written notice of its first level of review decision to you within 30 days from initial receipt of your complaint.
3. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described below, must be exhausted before you have the right to submit a request for external review.

Complaints that involve a medical necessity review by Medica:

1. Your complaint must be made within one year following Medica's initial decision and may be made orally or in writing.
2. Medica will provide written notice of its first level of review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint.
3. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review, you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.
4. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level of review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.
5. If your complaint involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of the review process.

Second level of review

If you are not satisfied with Medica's first level of review decision, you may request a second level of review through either a written reconsideration or a hearing.

1. Your request can be oral or in writing. It must be provided to Medica within one year following the date of Medica's first level review decision. If your request is in writing, it must be sent to the address listed above in **First level of review**.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation, or other information provided by you, Medica staff, providers, and others is reviewed.

3. Medica will provide written notice of its second level of review decision to you within:

   a. 30 calendar days from receipt of written notice of your appeal for required second level of review; or

   b. 45 calendar days from receipt of written notice of your appeal for optional second level of review.

   For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. Generally, a second level of review is optional if the complaint requires a medical necessity review. Medica will inform you in writing whether the second level of review is optional or required.

External review

If you consider Medica's decision to be partially or wholly adverse to you, you may submit a written request for external review of Medica's decision to the Commissioner of Commerce at:

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

You must submit your written request for external review within six months from the date of Medica's decision. You must include a filing fee of $25 with your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. Contact the Commissioner of Commerce for more information about the external review process.

Under most circumstances, you must complete all required levels of review, described above, before you proceed to external review. You may proceed to external review without completing the required levels of review if Medica agrees that you may do so, or if Medica fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines. For complaints that involve a medical necessity review, you may request an expedited external review at the same time you request an expedited first level of review. You may also request an expedited external review if Medica's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health, or ability to regain maximum function, or if Medica's decision concerns an admission, availability of care, continued stay, or health care service for which you received emergency services and you have not been discharged from a facility. If an expedited review is requested and approved, a decision will be provided within 72 hours.

If Medica's decision involves a treatment that Medica considers investigative, the review organization will base its decision on all documents submitted by you and Medica, your provider's recommendation, consulting reports from health care professionals, your benefits under this plan, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Complaints regarding fraudulent marketing practices or agent misrepresentation cannot be submitted for external review.

General Provisions

This section describes the general provisions of the plan.

Records

The sponsor, the plan administrator, Medica, and others to whom the sponsor has delegated duties and responsibilities under the plan shall keep accurate and detailed records of any matters pertaining to administration of the plan in compliance with applicable law.

Examination of a covered person

To settle a dispute concerning provision or payment of benefits under the plan, the plan administrator may require that you be examined or an autopsy of the covered person's body be performed. The examination or autopsy will be at the plan's expense.

Clerical error and misstatements

Should a clerical error be found or should any misstatement of relevant facts pertaining to coverage under the plan be found, and should such error or misstatement affect the existence or amount of coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage. For example, you will not be eligible for coverage beyond the scheduled termination of coverage because of a failure to record the termination. On the other hand, you will not be deprived of coverage under the plan because of a clerical error.

Plan amendment and termination

Any change or amendment to or termination of the plan, its benefits, or its terms and conditions, in whole or in part, whether prospective or retroactive, shall be made solely in a written amendment (in the case of a change or amendment) or in written resolution (in the case of termination) to the plan, approved by the Board of Directors (if a corporation), the general partner(s) (if a partnership), the proprietor (if a sole proprietorship) or similar governing body (in all other cases) of the sponsor or any of their designees to whom such Board of Directors, general partner(s), proprietor, or similar body has delegated in writing the foregoing authority. You will receive notice of any amendment to the plan in accordance with applicable law. No one has the authority to make any oral modification to the plan.

Applicable law

This plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) imposes certain obligations on employers. This plan shall be administered in a manner consistent with USERRA.

Enrollee rights

The action of the sponsor in creating this plan shall not be construed to constitute and shall not be evidence of any contractual relationship between the sponsor and any enrollee, or as a right of any enrollee to continue in the employment of the sponsor, or as a limitation of the right of the sponsor to discharge any of its employees, with or without cause.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) imposes certain obligations on employers with fifty (50) or more employees. This plan shall be administered in a manner consistent with the FMLA and the applicable employer's FMLA policy.

Reservation of discretion

The plan administrator and its delegate have the full discretionary power to interpret and apply the terms of the plan, and its components (including, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in the language of the plan and its underlying documents) as they relate to matters for which the named fiduciary has responsibility. All decisions of the plan administrator and its delegate as to the facts of the case, interpretation of any provisions of the plan, or its application to any case and any other interpretative matter, determination, or question under the plan will be final and binding on all affected parties.

Definitions

Words and phrases with specific meanings are defined in this section.

Approved clinical trial. A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition, is not designed exclusively to test toxicity or disease pathophysiology, and is described in any of the following subparagraphs:

1. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
2. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
3. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

Benefits. The health services or supplies (described in this plan and any subsequent amendments) approved by the plan as eligible for coverage.

Claim. An invoice, bill, or itemized statement for benefits provided to you.

Coinsurance. The percentage amount you must pay to the provider for benefits received. Full coinsurance payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

For in-network benefits, the coinsurance amount is based on the lesser of the:

1. Charge billed by the provider (i.e., retail); or
2. Negotiated amount that the provider has agreed to accept as full payment for the benefit (i.e., wholesale).

When the wholesale amount is not known nor readily calculated at the time the benefit is provided, Medica, on behalf of the sponsor, uses an amount to approximate the wholesale amount. For services from some network providers, however, the coinsurance is based on the provider's retail charge. The provider's retail charge is the amount that the provider would charge to any patient, whether or not that patient is a covered person of Medica.

For out-of-network benefits, the coinsurance will be based on the lesser of the:

1. Charge billed by the provider (i.e., retail); or
2. Non-network provider reimbursement amount.

For out-of-network benefits, in addition to any coinsurance and deductible amounts, you will be responsible for any charges billed by the provider in excess of the non-network provider reimbursement amount.

The coinsurance may not exceed the charge billed by the provider for the benefit.

Complaint. Any grievance against Medica, submitted by you or another person on your behalf, that is not the subject of litigation. Complaints may involve, but are not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or non-renewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former covered person, the complaint must relate to services received during the time the individual was a covered person.

Convenience care/retail health clinic. A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, which provides treatment of common illnesses and certain preventive health care services.

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not medically necessary, or as determined by the plan.

Covered person. A person who is enrolled under the plan.

Creditable coverage. Health coverage provided under one of the following plans:

1. A group health benefit plan, including a self-insured plan;
2. Health insurance coverage, whether through a group or individual contract;
3. Medicare;
4. Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines);
5. A state health benefit risk pool;
6. A military health plan or other coverage provided under United States Code, title 10, chapter 55;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. The Federal Employees Health Benefits Program or other similar coverage provided under federal law applicable to government organizations and employees;
9. A health benefit plan provided under Section 5(e) of the federal Peace Corps Act;
10. State Children’s Health Insurance Program; or

11. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.

Coverages of the following types, including any combination of the following types, are *not* creditable coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance;
4. Workers' compensation insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Limited scope dental or vision coverage;
9. Coverage for long-term care, nursing home care, home health care, community-based care, or any combination of these;
10. Coverage only for a specified disease or illness;
11. Hospital indemnity or other fixed indemnity insurance; or
12. Medicare supplemental health insurance, benefits supplemental to military health care, and similar supplemental coverage if such benefits are provided under a separate policy or contract of insurance.

Custodial care. Services to assist in activities of daily living that do not seek to cure, are performed regularly as a part of a routine or schedule, and, due to the physical stability of the condition, do not need to be provided or directed by a skilled medical professional. These services include help in walking, getting in or out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that can usually be self-administered.

Deductible. The fixed dollar amount you must pay for eligible services or supplies before claims for health services or supplies received from providers are reimbursable as benefits under this plan.

Dependent. Unless otherwise specified in the plan, the following are considered dependents:

1. The enrollee's spouse.
2. The following dependent children up to the dependent limiting age of 26:
    a. The enrollee's or enrollee's spouse's natural or adopted child;
    b. A child placed for adoption with the enrollee or enrollee's spouse;

c. A child for whom the enrollee or the enrollee's spouse has been appointed legal guardian; however, upon request by the plan, the enrollee must provide satisfactory proof of legal guardianship;

d. The enrollee's stepchild; and

e. A child placed as a foster child with the enrollee or the enrollee's spouse; and

f. The enrollee's or enrollee's spouse's unmarried grandchild who is dependent upon and resides with the enrollee or enrollee's spouse continuously from birth.

For residents of a state other than Minnesota, the dependent limiting age may be higher if required by applicable state law.

3. The enrollee's or enrollee's spouse's disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. This dependent may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.

4. The enrollee's or enrollee's spouse's disabled dependent who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability and dependency at the time of the dependent's enrollment.

Designated facility. A network hospital that Medica has authorized to provide certain benefits to covered persons, as described in this plan.

Designated physician. A network physician that Medica has authorized to provide certain benefits to covered persons, as described in this plan.

Emergency. A condition or symptom (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate treatment to:

1. Preserve your life; or

2. Prevent serious impairment to your bodily functions, organs, or parts; or

3. Prevent placing your physical or mental health (or, if you are pregnant, the health of your unborn child) in serious jeopardy.

Employee. Any person employed by the sponsor on or after the effective date of this plan, except that it shall not include a self-employed individual as described in Section 401(c) of the

Code. All employees who are treated as employed by a single employer under Subsections (b), (c), or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this plan. Employee does not include any of the following:

1. Any employee included within a unit of employees covered under a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this plan;
2. Any employee who is a nonresident alien and receives no earned income from the sponsor from sources within the United States; and
3. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code.

Enrollee. A qualified employee who the plan administrator determines is enrolled under the plan.

Enrollment date. The date of the qualified employee's or dependent's first day of coverage under the plan or, if earlier, the first day of the waiting period for the qualified employee's or dependent's enrollment.

Genetic testing. An analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. Genetic testing includes pharmacogenetic testing. Genetic testing does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, an HIV test, complete blood count, or cholesterol test is not a genetic test.

Habilitative. Health care services are considered habilitative when they are provided to improve an impairment in physical function or speech due to congenital or developmental conditions, including autism spectrum disorders, that have impeded normal speech and motor development.

HIPAA privacy standards. Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended, and codified at 45 CFR Parts 160 and 164.

Hospital. A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative, and surgical services by, or under the direction of, a physician and with 24-hour R.N. nursing services. The hospital is not mainly a place for rest or custodial care, and is not a nursing home or similar facility.

Inpatient. An uninterrupted stay, following formal admission to a hospital, skilled nursing facility, or licensed acute care facility. Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

Investigative. As determined by the plan, 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. The plan will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II, or III trials;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by the plan to be investigative. The plan will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines, or parameters approved by national health professional boards or associations, and entries in any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

Late enrollee. A qualified employee or dependent who requests enrollment under the plan other than during:

1. The initial enrollment period set by the sponsor; or
2. The open enrollment period set by the sponsor; or
3. A special enrollment period as described in **Eligibility and Enrollment**.

In addition, a covered person who is a child entitled to receive coverage through a medical support order is not subject to any initial or open enrollment period restrictions.

Life-threatening condition. Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medical necessity review. Medica's evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, for the purpose of determining the medical necessity of the service or admission.

Medically necessary. Diagnostic testing and medical treatment, consistent with the diagnosis of and prescribed course of treatment for your condition, and preventive services. Medically necessary care must meet the following criteria:

1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
2. Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and
3. Help to restore or maintain your health; or
4. Prevent deterioration of your condition; or
5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Mental disorder. A physical or mental condition having an emotional or psychological origin, as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility, or pharmacy) that has entered into a written agreement to provide benefits to you. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically, without charge.

Non-network. A provider not under contract as a network provider.

Non-network provider reimbursement amount. The amount that Medica, on behalf of sponsor, will pay to a non-network provider for each benefit is based on one of the following, as determined by Medica, on behalf of sponsor:

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica generally updates its data on the amount Medicare pays within 30-60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or
2. A percentage of the provider's billed charge; or
3. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or
4. An amount agreed upon between Medica, on behalf of sponsor, and the non-network provider.

Contact Customer Service for more information concerning which method above pertains to your services, including the applicable percentage if a Medicare-based approach is used.

For certain benefits, you must pay a portion of the non-network provider reimbursement amount as a coinsurance.

In addition, if the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, the non-network provider will likely bill you for the difference. This difference may be substantial, and it is in addition to any coinsurance or deductible amount you may be responsible for according to the terms described in this plan. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **Benefits & Coverage**. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. As a result, the amount you will be required to pay for services received from a non-network provider will likely be much higher than if you had received services from a network provider.

Out-of-pocket maximum. An accumulation of coinsurance and deductibles paid for benefits received during a calendar year. Unless otherwise specified, you will not be required to pay more than the applicable per covered person out-of-pocket maximum for benefits received during a calendar year.

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by the plan, or charge in excess of the non-network provider reimbursement amount.

There are separate in-network and out-of-network out-of-pocket maximums for this plan. Once your out-of-pocket maximum for in-network and out-of-network is met, then other benefits in the same category are covered at 100 percent. For example, if your eligible out-of-pocket maximum for in-network benefits is met, all in-network benefits for the remainder of the calendar year are covered at 100 percent, but your out-of-network benefits will not be covered at 100 percent until that out-of-pocket maximum is met.

The plan refunds the amount over the out-of-pocket maximum during any calendar year when proof of excess coinsurance and deductibles is received and verified by the plan.

Pharmacogenetic testing. A type of genetic testing that attempts to use personal gene-based information to determine the proper drug and dosage for an individual. Pharmacogenetic testing seeks to determine how a drug is absorbed, metabolized, or cleared from the body of an individual based on their genetic makeup.

Physician. A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.) practicing within the scope of his or her licensure.

Placed as a foster child. The acceptance of the placement in your home of a child who has been placed away from his or her parents or guardians in 24-hour substitute care and for whom a state agency has placement and care responsibility. Eligibility for a child placed as a foster child with the enrollee or enrollee's spouse ends when such placement is terminated.

Placed for adoption. The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child. Eligibility for a child placed for adoption with the enrollee ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.

Plan. The plan of health care coverage established by sponsor for its covered persons, as this plan currently exists or may be amended in the future.

Plan administration functions. Administration functions performed by sponsor on behalf of the plan (such as quality assurance, claims processing, auditing, and other similar functions). Plan administration functions do not include functions performed by sponsor in connection with any other benefit or benefit plan of sponsor.

Plan administrator. Sibley/McLeod County.

Prenatal care. The comprehensive package of medical and psychosocial support provided throughout a pregnancy and related directly to the care of the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by *Standards for Obstetric-Gynecologic Services* issued by the American College of Obstetricians and Gynecologists.

Prescription drug. A drug approved by the FDA for the prescribed use and route of administration.

Preventive health service. The following are considered preventive health services:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
3. With respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. With respect to covered persons who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Contact Customer Service for information regarding specific preventive health services, services that are rated A or B, and services that are included in guidelines supported by the Health Resources and Services Administration. For a list of preventive health services please sign in at medica.com.

Protected health information or PHI. With some exceptions, information that: (i) identifies or could reasonably be used to identify you; and (ii) relates to your physical or mental health or condition, the provision of your health care, or your payment for health care.

Provider. A health care professional or facility licensed, certified, or otherwise qualified under state law to provide health services.

Qualified employee. An employee of sponsor. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the

sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

Qualified individual. (1) An individual who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening conditions, and (2) either (a) the referring health care professional is a network provider and has concluded that the individual's participation in the trial would be appropriate, or (b) the individual provides medical or scientific information establishing that their participation would be appropriate.

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your physician.

In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered reconstructive.

Rehabilitative. Health care services are considered rehabilitative when they are provided to restore physical function or speech that has been impaired due to illness or injury.

Restorative. Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is medically necessary.

Retiree. A former employee who is an enrollee under the plan immediately preceding retirement and who, upon retirement:

1. Is receiving a disability benefit from a Minnesota public pension plan other than a volunteer firefighter plan or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan; or
2. Has met age and service requirements to receive an annuity from such a plan as described in 1. above.

Routine foot care. Services that are routine foot care may require treatment by a professional and include but are not limited to any of the following:

1. Cutting, paring, or removing corns and calluses;
2. Nail trimming, clipping, or cutting; and
3. Debriding (removing toenails, dead skin, or underlying tissue).

Routine foot care may also include hygiene and preventive maintenance such as:

1. Cleaning and soaking the feet; and
2. Applying skin creams in order to maintain skin tone.

Routine patient costs. All items and services that would be covered benefits if not provided in connection with a clinical trial. In connection with a clinical trial, routine patient costs do not include an investigative or experimental item, device, or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Skilled care. Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for skilled care.

Skilled nursing facility. A licensed bed or facility (including an extended care facility, hospital swing-bed, and transitional care unit) that provides skilled nursing care, skilled transitional care, or other related health services including rehabilitative services.

Sponsor. Sibley/McLeod County.

Total disability. Disability due to injury, sickness, or pregnancy that requires regular care and attendance of a physician, and in the opinion of the physician renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability and, after the first two years of the disability, renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted.

Urgent care center. A health care facility distinguishable from an affiliated clinic or hospital whose primary purpose is to offer and provide immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

Virtual care. Professional evaluation and medical management services provided to patients through e-mail, telephone, or webcam. Virtual care includes interactive audiovisual telehealth services. Virtual care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results, or solely calling in a prescription to a pharmacy.

Waiting period. In accordance with applicable state and federal laws, the period of time, as determined by the sponsor's eligibility requirements, that must pass before a qualified employee and/or dependent becomes covered under the plan. However, if a qualified employee and/or dependent enrolls as a late enrollee or through either an open enrollment period or a special enrollment period as set forth herein in **Eligibility and Enrollment**, any period before such late, open, or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Signature

IN WITNESS WHEREOF, the _____ of the sponsor has executed the foregoing plan on behalf of sponsor on this _____ day of _____, _____.

Sibley County

By: _____
(please print)

_____
(signature)

Its: _____

McLeod County

By: _____
(please print)

_____
(signature)

Its: _____

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

SIBLEY/MCLEOD COUNTY

AND

MEDICA SELF-INSURED

EFFECTIVE

JANUARY 1, 2016

GROUP HEALTHCARE COVERAGE

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") is effective January 1, 2016 ("Effective Date") by and between Sibley/McLeod County ("Sponsor"), Plan Administrator, and Medica Self-Insured ("MSI").

WHEREAS, Sponsor has established one or more Plans, as defined below, to provide health care coverage ("Plan") for its employees, their dependents or other eligible persons and Sponsor desires to arrange for MSI to provide certain administrative services in connection with the Plan.

WHEREAS, Sponsor has requested MSI to provide the services found in this Agreement and the Addenda.

WHEREAS, MSI is considered a "business associate" under HIPAA with regard to the certain benefit plans, there is an exhibit to document compliance with HIPAA's privacy, security, and electronic data interchange (EDI) requirements.

NOW THEREFORE, the parties agree as follows:

SECTION 1. DEFINITIONS.

In addition to the terms defined elsewhere in this Agreement, for purposes of this Agreement and the attached Addendum, the following terms shall have the meanings set forth below. Unless the context otherwise requires, words in the singular number include the plural and those in the plural include the singular.

"Addenda" or **"Addendum"** means the documents attached to this Administrative Services Agreement that more specifically spell out the administrative services for the different Plans adopted by Sponsor.

"Affordable Care Act" or **"ACA"** means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010 and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010 and implementing regulations.

"Cafeteria Plan" means a salary reduction plan established by the Sponsor under Code § 125.

"Claim" means a request for payment under an applicable benefit plan or arrangement.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and its implementing regulations.

"Code" means the Internal Revenue Code of 1986, as amended and its implementing regulations.

"Contract Year" shall have the meaning set forth in Section 6.1 of this Agreement.

"Covered Employee" means an employee meeting the requirements set by Sponsor for enrollment under the Plans and enrolled for coverage under the Plans.

"Dependent" means a Covered Employee's spouse and dependents, as determined by Plan Sponsor.

"Group Healthcare Coverage" means the self-funded plan established by Sponsor for its employees, their dependents or other eligible persons, as that plan currently exists or may be amended in the future.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended and its implementing regulations.

"MSI" means the claims administrator with whom the Sponsor contracts via this Agreement to perform certain limited administrative services with respect to the medical benefits provided through the Plans. This Agreement is for administrative services only.

"Plan" means one or more of the following: the Group Healthcare Coverage plan, the Health Reimbursement Arrangement, and the component plans under a Cafeteria Plan through which Covered Employees can elect different benefits. Each is referred to individually as a Plan and collectively as the Plans.

"Plan Administrator" means the person or other such entity, as stated in the Plan Documents, that is responsible for the administration of the Plans.

"Plan Document(s)" means the document(s) provided to Covered Employees establishing and setting forth the terms and conditions of this Plan and the Plan's coverage.

"Premium Equivalent" means the cost per Covered Employee, or the amount Plan Sponsor would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.

"Sponsor" means the employer group identified in the Plan Documents as the Sponsor of the Plans. Such employer group has financial responsibility for such Plan and has entered into an administrative services agreement with MSI related to such Plan.

SECTION 2. SPONSOR OBLIGATIONS.

2.1 Establishment of the Plans. Sponsor is solely responsible for establishing and maintaining the Plans, including adoption of Plan Document(s) and any Plan amendments. The Sponsor retains all authority to amend, alter, or modify the terms of the Plans. Sponsor may amend the Plan Documents in its sole discretion, but Sponsor shall give MSI written notice of any such amendment at least 60 days before its effective date, unless the parties mutually agree to a different notice period. Plan Administrator is responsible for determining, for regulatory purposes, the number of plans that have been adopted by Sponsor.

2.2 Fiduciary. Sponsor is considered the Plan Administrator. Sponsor shall not name MSI or represent that MSI is, and MSI shall not be, the Plan Administrator.

2.3 Eligibility and Enrollment. Before the Effective Date of this Agreement and before the beginning of any subsequent Contract Year, Sponsor shall provide MSI with information regarding each Covered Employee and Dependents, on a form satisfactory to both parties, and shall notify MSI of any changes in the eligibility of a Covered Employee and Dependents and any addition or deletion of Covered Employees and Dependents to the Plans. The Plan Administrator shall determine Covered Employee and Dependent eligibility and shall inform MSI of those individuals to be enrolled in or disenrolled from the Plans. MSI shall be entitled to rely on the most current information in its possession regarding eligibility of Covered Employees and Dependents in paying Claims and providing other services under this Agreement.

2.4 Plan Documents. Sponsor shall provide MSI with the Plan Documents adopted by Sponsor, including any amendments, in order that MSI has sufficient direction to administer the Plans, as described in this Agreement.

2.5 **Records.** Plan Administrator shall maintain records relating to the terms and operation of the Plans, including the identification of eligible persons, payments to MSI and payments for benefits.

2.6 **Regulatory Compliance.**

(a) **Code.** Sponsor and Plan Administrator shall be solely responsible for compliance with all Internal Revenue Code requirements related to the administration of the Plans, including, but not limited to, required discrimination testing, payment of the Comparative Effectiveness Research fee under the ACA, and any other penalty or fee under the ACA.

(b) **COBRA.** All duties of the Sponsor and Plan Administrator, including, but not limited to, notifying Covered Employees regarding continuation rights and premium billing and collection, remain the responsibility of Sponsor and Plan Administrator.

(c) **Election Changes.** Sponsor is solely responsible for determining if election changes are allowed in accordance with the requirements of Code § 125.

(d) **Affordable Care Act.** Sponsor has sole responsibility for determination of whether any Plan is subject to the ACA. If such Plan is subject to the ACA, Sponsor shall be solely responsible for compliance with the requirements of the ACA.

(e) **Grandfather Status.** Sponsor has sole responsibility for determining if any Plan is "grandfathered," as that term is defined in §§ 1251 and 10103(d) of the ACA. In the event Sponsor determines that a plan is grandfathered, MSI will put the appropriate language on Covered Employee communications as required by the ACA and any implementing regulations or regulatory guidance. MSI will provide suggested language for the required disclosure of grandfather status. Sponsor is solely responsible for determining the final content of the required language.

(f) **Compliance with HIPAA Privacy and Security Regulations.** Compliance with any and all applicable provisions of the privacy and security regulations issued pursuant to HIPAA shall be the responsibility of the Plans. Plan Sponsor and MSI's obligations under HIPAA are set forth in Exhibit 2.6(f) – Business Associate Agreement attached hereto and incorporated by reference.

(g) **Medical Support Orders.** Plan Administrator shall be responsible for all aspects of compliance regarding medical support orders. MSI shall be entitled to rely on the information provided by Plan Administrator regarding medical support orders.

(h) **Other Group Health Plan Laws.** Sponsor shall take all other steps necessary to maintain and operate the Plans in compliance with applicable provisions of other applicable federal and state laws.

SECTION 3. GENERAL SERVICES PROVIDED BY MSI.

MSI shall provide only those administrative services described in this Agreement and the Addendum attached hereto and incorporated by reference consistent with the Plan

Documents. The parties understand and acknowledge that MSI shall provide its services in accordance with its usual and customary business practices.

3.1 **Limited Duties.** The Plan Sponsor delegates to MSI only non-discretionary authority with respect to assisting Plan Sponsor in the development, maintenance and administration of the Plans as specifically described in this Agreement. MSI cannot provide tax or legal advice with respect to the Plans. Sponsor is solely responsible for consulting with its tax and benefits advisors regarding tax, ERISA, and other legal matters involving the Plans.

3.2 **Administrative Services.** MSI shall provide those administrative services for the benefits as described more fully in the Addendum attached hereto, which by reference are incorporated in this Agreement. Each Addendum describes more specifically the services and requirements for the Plan. Sponsor acknowledges that MSI is not administering any Cafeteria Plan through which certain benefits are provided. In order for MSI to be bound to provide administrative services relating to any amendment to the Plan Documents that would increase or change the nature of the services provided by MSI, MSI must have specifically agreed to provide such services. In the event MSI agrees to provide such additional or changed services, MSI may request renegotiation of the fees paid to MSI pursuant to this Agreement. In the event MSI does not agree to provide the additional or changed services, or the parties cannot agree on a new fee, MSI may terminate this Agreement upon 30 days written notice to Sponsor.

Except as specifically provided in this Agreement, MSI shall have no obligation to provide any services under this Agreement relating to a claim or other event regarding health care delivered before the Effective Date or after the termination date of this Agreement except as set forth in Section 6.3.

3.3 **Licenses.** MSI will obtain and maintain any licenses or regulatory approvals necessary for it to perform its services under this Agreement.

3.4 **Plan Document Drafting.** MSI shall provide Sponsor with draft Plan Document(s) for Sponsor's review and consideration. Sponsor shall be solely responsible for the final content of Sponsor's Plan Document. If MSI determines that the content and format of Sponsor's final Plan Document is substantially similar to the draft document provided by MSI, MSI shall provide Sponsor with an electronic Plan Document. If MSI determines that the content and format of Sponsor's final Plan Document is not substantially similar to the draft document provided by MSI, Sponsor shall produce and shall bear the cost of printing and distributing the Plan Documents.

3.5 **Employee Meetings.** MSI, upon request, will attend any informational meetings for potential Covered Employees relating to the Plans and shall cooperate with Sponsor's efforts to provide information regarding the Plans.

3.6 **Customer Service.** MSI shall respond to written or telephone requests for information made during normal business hours by Covered Employees and Dependents insofar as the inquiry can be addressed under the terms of this Agreement or per the Plan Documents.

3.7 **Recordkeeping.** MSI shall maintain records relating to its responsibilities under this Agreement and shall provide Plan Administrator with records requested by Sponsor and Plan Administrator, subject to Section 4.

3.8 Department of Labor Reporting. In the event Plan Administrator determines that the Plans are required to file a Form 5500 Schedule C, MSI will provide the necessary information to Plan Administrator upon request.

SECTION 4. RECORDS AND REPORTS.

4.1 Records. Any release of records or access to records under this Section 4.1 is subject to the confidentiality provision in Section 4.4.

Each party may have access to the records, as permitted by law, directly relating to the Plans and maintained by the other party during normal business hours and upon reasonable notice. The party requesting records shall pay the cost of photocopying. The party inspecting or auditing records shall, at the request of the party holding the records, pay (i) for personnel time expended in connection with complying with the inspection or audit, to the extent such personnel time exceeds 24 hours; and (ii) any other costs incurred in complying with the audit or inspection request.

Plan Administrator hereby authorizes MSI to access any Covered Employee information, including information held by any third party, that MSI deems necessary for Plan administration purposes. Sponsor and Plan Administrator acknowledge and agree, on behalf of themselves and the Plans, that subject to the provisions of Exhibit 2.6(f), MSI may use and transfer claims and related medical data in MSI's possession to third parties for purposes of research and analysis.

It is the Plan Administrator's responsibility to maintain all records on behalf of the Plans. However, in the event of the termination of this Agreement, MSI shall provide Plan Administrator with copies of records in MSI's possession relating to the Plans and necessary for the continued operation of the Plans. The copies may be provided in hard copy or machine readable form, in MSI's discretion. All records generated or maintained by MSI as necessary for MSI to provide administrative services relating to the Plans shall be kept for 7 years after the last day of the Plans' year to which the document relates or any applicable period required by law, whichever is longer.

4.2 Reports. Any provision of reports under this Section 4.2 is subject to the confidentiality provision in Section 4.4. Plan Administrator will have access to MSI's on-line reporting tool. In the event Sponsor or Plan Administrator requests that MSI provide information other than information in standard reports, Sponsor shall be responsible for the cost of such reports.

4.3 Audits. During the term of this Agreement, and at any time within twelve (12) months following its termination, Sponsor or its designee may audit MSI to determine whether MSI is fulfilling the terms of this Agreement. Sponsor must advise MSI at least forty-five (45) days in advance of its intent to audit. The auditor chosen by Sponsor shall execute a confidentiality agreement. The place, time, type, duration and frequency of all audits must be reasonable and agreed to by MSI. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year unless the parties agree to a longer time period. In no event, however, shall any audit or inspection of Plan include records dated more than 7 years from the last day of the Plan year to which the audit relates. With respect to Claims services, the audit scope and methodology shall be consistent with generally acceptable

auditing standards, including a statistically valid random sample or other acceptable audit technique. Sponsor will provide MSI with a copy of the audit report.

MSI recognizes that regulatory audits may occur outside the timeframes set forth above. MSI shall make available to representatives of the appropriate regulatory agencies, all requested books and records and access to its operating procedures in accordance with regulatory requirements. In no event, however, shall any audit or inspection of Plan include records dated more than 7 years from the last day of the Plan year to which the audit relates.

4.4 Confidentiality.

(a) Proprietary Information. In order to assist Plan Administrator in administering the Plan, MSI may reveal certain confidential information ("Information") that is not PHI. For purposes of this Section 4.4, "Information" will mean all nonpublic information that is related to the business or operations of MSI, including, but not limited to, information specifically identified as confidential, information generally understood to be confidential, commercial and financial information, and trade secret information. MSI shall not be required to disclose provider payment fee schedules, individually or in the aggregate, or other proprietary or confidential business information unless required under applicable law. Information shall not include: 1) information that is already at the signing of this Agreement in Sponsor or Plan Administrator's possession; 2) information that has come into the public domain through no fault of or action by Plan Administrator or Sponsor; 3) information that is required to be disclosed in response to official inquiries from any state or federal agency or by court order; 4) information that is obtained after the fact by a third party that has no legal restriction on disseminating such information.

(b) Protected Health Information. Uses and disclosures of PHI are governed by the terms of the Business Associate Agreement attached as Exhibit 2.6(f).

SECTION 5. PAYMENTS BY SPONSOR.

5.1 Benefits. Payment from General Assets of Sponsor. Sponsor shall use funds from its general assets to make payments for benefits and fees to MSI. Sponsor shall not set up a trust or an account in the Plan's name to be used to pay for benefits or fees to MSI. Plan Sponsor acknowledges and agrees that Plan Sponsor is responsible for funding payment for all benefits. Plan Sponsor's financial obligation is not limited to the Premium Equivalent amounts funded through the HRA.

If Sponsor does not make funds available to pay Claims in the required amount and Sponsor fails to provide the required amount of funds within two business days after notice of the need to provide such funds, MSI may immediately terminate this Agreement and its obligations under this Agreement, as provided in Section 6.2 below.

MSI shall forward to Sponsor a report itemizing amounts payable for Claims during that period, and a report setting forth administrative fees due MSI. MSI shall adjust any claim disputes by Sponsor, or errors detected by MSI or

Sponsor, in the supporting reports for the next period's payment due after the dispute is resolved or errors identified.

5.2 **Fees.** Sponsor shall use funds from its general assets to make payments to MSI for administrative fees. The administrative fees are set forth in Exhibit 5.2, attached hereto and incorporated by reference. If MSI's performance under this Agreement is made materially more burdensome or expensive due to (i) a change in federal, state, or local laws or regulations; or (ii) a new application of existing laws or regulations, the parties shall negotiate an appropriate adjustment to the fee paid to MSI. If the parties cannot agree on an adjusted fee within 30 days after MSI sent written notice of the material change and its request to negotiate an adjusted fee to Sponsor, then either party may terminate this Agreement upon 30 days written notice to the other party.

MSI shall forward to Sponsor a report setting forth administrative fees due MSI. MSI shall adjust any fee disputes by Sponsor, or errors detected by MSI or Sponsor, in the supporting reports for the next period's payment due after the dispute is resolved or errors identified.

5.3 **MSI Access to Plan Data.** Sponsor hereby authorizes MSI to have access to any and all Plan financial information, including without limitation, bank account information, which MSI may deem necessary or convenient for MSI to perform or review the provision of services on behalf of the Plans.

SECTION 6. TERM AND TERMINATION.

6.1 **Term.** This Agreement shall become effective on the Effective Date for a one-year period (a "Contract Year"), ending December 31, 2016, unless earlier terminated as provided in this Agreement; provided, however, that this Agreement shall renew for successive Contract Years, commencing January 1 and ending December 31, subject to section 6.2(a).

6.2 **Termination.**

(a) This Agreement will terminate at the end of a Contract Year if either party gives the other party written notice of its intent not to renew this Agreement at least 60 days in advance of the commencement of any Contract Year unless a shorter period of time is mutually agreed to by the parties.

(b) This Agreement will terminate at the end of a Contract Year if MSI and Sponsor fail to reach agreement on the fees described in Exhibit 5.2 at least 60 days in advance of the commencement of any Contract Year and the parties determine that an agreement is not possible, unless the parties agree otherwise.

(c) If Sponsor fails to make any payment to MSI when such payment is due under this Agreement, MSI may terminate this Agreement effective immediately upon written notice to the Sponsor.

(d) Either party may terminate this Agreement in the event of a material default, other than a failure to pay described in Section 6.2(c) above, by the other party. Such termination shall be effective 60 days after written notice specifying the default has been given to the defaulting party, unless the default has been cured before the end of the 60-day period.

(e) Sponsor may terminate this Agreement effective immediately upon written notice to MSI in the event that MSI fails to obtain or maintain any required licenses or regulatory approvals necessary for it to perform services under this Agreement.

(f) Sponsor may terminate this Agreement immediately upon MSI's material breach of the terms of Exhibit 2.6(f) if cure of the breach by MSI is not possible.

(g) MSI may terminate this Agreement effective immediately upon written notice to Sponsor and Plan Administrator in the event Sponsor ceases to be actively engaged in business or if the Plans are terminated.

(h) Subject to applicable law, MSI may terminate this Agreement effective immediately upon written notice to Sponsor and Plan Administrator in the event Sponsor admits in writing to its inability to pay its debts, makes a general assignment for the benefit of creditors, is adjudicated insolvent, or is placed in receivership. Sponsor agrees that it shall provide MSI with immediate written notice upon the occurrence of any of the events described in this Section 6.2(h).

(i) This Agreement may be terminated as provided elsewhere in this Agreement.

(j) Either Party may terminate this Agreement without cause upon 90 days prior written notice.

6.3 Cooperation Upon Termination.

In the event of termination of this Agreement for any reason:

(a) MSI shall provide reasonable cooperation to the person or entity selected by Sponsor or Plan Administrator to assume administration of the Plans;

(b) Sponsor and Plan Administrator shall cooperate with the processing of incurred but not reported claims by MSI, and Sponsor shall provide funds in amounts necessary to pay such Claims and any administrative fee payable to MSI;

(c) To the extent that following the date of termination, Sponsor pays to MSI (i) all amounts previously due and payable, as described in Section 6.3(b); and (ii) funds in amounts described in Section 5.1 and Exhibit 5.2 of this Agreement, MSI shall process any incurred but not reported claims or other claims existing on the date of termination; provided, however, that in no event shall MSI process any such claims more than 6 months following the date of termination unless a different period is provided for in an Addendum; and

(d) In addition to funding claims, Sponsor shall pay MSI 100% of the administrative fees provided for in Section 5.2 for the 3 months following termination, calculated based upon the number of Covered Employees, determined on the first day of the calendar month in which this Agreement is terminated, unless a different period is provided for in an Addendum.

SECTION 7. INDEMNIFICATION.

7.1 MSI's Indemnification Obligations. MSI will defend, hold harmless and indemnify the Plan Sponsor, the Plan Administrator and any of its officers, agents

and employees against any and all claims, liabilities, damages, judgments or expenses (including reasonable attorney's fees) asserted or against, imposed upon or incurred by the Plan Sponsor, the Plan Administrator or any of its officers, agents and employees that arise out of the willful misconduct or negligent acts or omissions of MSI or its employees, agents or representatives in the discharge of its or their responsibilities under this Agreement.

7.2 Sponsor's Indemnification Obligations. Plan Sponsor and Plan Administrator will defend, hold harmless and indemnify MSI and any of its officers, agents and employees against any and all claims, liabilities, damages, judgments or expenses (including reasonable attorney's fees) asserted or against, imposed upon or incurred by MSI or any of its officers, agents and employees that arise out of the willful misconduct or negligent acts or omissions of Plan Sponsor, Plan Administrator or their employees, agents or representatives in the discharge of its or their responsibilities under this Agreement.

7.3 Inapplicability/Exceptions to Indemnification Obligations. The Plan Sponsor shall remain solely responsible for payments for properly owed benefits and MSI shall have no indemnification obligations related to the payment for benefits if the payment of such benefits was required regardless of any acts or omissions of MSI. MSI shall not have any indemnification obligations for its acts or omissions related to the receipt of written instructions, written directives or incomplete, inaccurate or untimely information from the Plan Sponsor, the Plan Administrator, the Employer or any of its authorized agents, representatives or employees. The Plan Sponsor shall not have any indemnification obligations for its acts or omissions related to the receipt of written instructions, written directives or incomplete, inaccurate or untimely information from MSI, its authorized agents, representatives or employees.

SECTION 8. DISPUTES AND LITIGATION.

8.1 Disputes. For the purposes of this section, "Dispute" means any dispute or claim between Sponsor and MSI arising out of or related to the interpretation or application of this Agreement or breach thereof.

8.2 Negotiation and Resolution of Disputes. In the event that any dispute, claim or controversy of any kind or nature relating to this Agreement arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. The party requesting the meeting shall provide the other, in advance of the meeting, with written notice of the claimed dispute. Upon receipt of the written notice, representatives for each party shall meet promptly to attempt to resolve the dispute. If a mutually agreeable resolution is not reached within thirty (30) days following receipt of the written notice, either party may pursue legal action in accordance with the terms of this Agreement. The parties may mutually agree to waive the informal dispute resolution process set forth herein. Any such waiver must be in writing and executed by both parties.

SECTION 9. GENERAL PROVISIONS.

9.1 Entire Agreement. This Agreement includes the entire understanding of the parties and supersedes all prior oral and written agreements relating to the same subject matter.

9.2 Independent Contractor Relationship. The relationship between the parties is solely one of independent contractors and nothing in this Agreement shall be

construed or deemed to create any other relationship between the parties, including one of employment, agency, or joint venture, unless specifically set forth herein.

9.3 **Assignment and Delegation.** MSI may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with MSI. If MSI assigns all or any of its rights or responsibilities under this Agreement, MSI will notify the Plan Administrator in writing of such assignment. MSI may delegate certain of its obligations under this Agreement to persons under contract with MSI. Neither Sponsor nor Plan Administrator shall assign any of their rights and responsibilities under this Agreement to any person or entity without the prior written consent of MSI, which consent shall not be unreasonably withheld.

9.4 **Notices.** All notices required under this Agreement shall be given in writing, signed by the party giving notice and delivered by hand, overnight delivery, or first-class mail and

(a) if intended for MSI, then the notice shall be addressed:

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305
Attn: Vice President & General Manager, Client Retention & Growth

Mailing Address:
Medica Self-Insured
P.O. Box 9310
Minneapolis, MN 55440-9310
Attn: Vice President & General Manager, Client Retention & Growth

(b) if intended for Sponsor, then the notice shall be addressed:

McLeod County
830 11th Street E
Glencoe, MN 55336
Attn: County Administrator

Sibley County
P.O. Box 256
400 Court Avenue
Gaylord, MN 55334
Attn: Human Resource Director

(c) if intended for Plan Administrator, then the notice shall be addressed:

McLeod County
830 11th Street E
Glencoe, MN 55336
Attn: County Administrator

Sibley County
P.O. Box 256
400 Court Avenue
Gaylord, MN 55334
Attn: Human Resource Director

or to such other address as any party may have furnished to the other in writing as the place for the service of notice. Each party agrees to notify the other in the event there is a change in the person who is to receive notice or the address where notice should be sent.

9.5 **Amendment for Regulatory Compliance.** Subject to Section 2.6 of this Agreement, in the event that any state or federal legislative or executive body enacts or promulgates legislation or regulation affecting the obligation of the parties under this Agreement, the parties agree to amend this Agreement in order to comply with any such legislation or regulation.

9.6 **No Waiver of Rights.** The failure of any party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy.

9.7 **Governing Law.** To the extent that state law applies, this Agreement shall be governed by the laws of the state of Minnesota. Any legal action under this Agreement shall be brought in the federal district court for the district of Minnesota.

9.8 **Headings.** The section headings contained in this Agreement are inserted for convenience only and shall not affect in any way the meaning or interpretation of this Agreement.

9.9 **Amendment.** This Agreement may be amended only in writing signed by each of the parties. Notwithstanding the foregoing, Sponsor is solely responsible for establishing and maintaining the Plans, including adoption of a Plan Document and any Plan amendments, as set forth more specifically elsewhere in this Agreement.

9.10 **Conflict.** If the terms of this Agreement conflict with the terms of any Addendum, the terms of the Addendum shall control administration of the applicable Plan.

9.11 **Survival.** The provisions of Section 2.6 Regulatory Compliance, Section 4 Records and Reports, Section 6.3 Cooperation Upon Termination, Section 7 Indemnification, and Section 8 Disputes and Litigation survive any termination of this Agreement.

Medica Self-Insured
P.O. Box 9310
Minneapolis, MN 55440-9310

By:

Paul Crowley
Vice President & General Manager,
Client Retention & Growth

Sponsor
Sibley County
P.O. Box 256
400 Court Avenue
Gaylord, MN 55334

By_____

Its_____

Dated_____

Plan Administrator
McLeod County
830 11th Street E
Glencoe, MN 55336

By_____

Its_____

Dated_____

SELF-FUNDED GROUP HEALTH PLAN

ADMINISTRATIVE SERVICES ADDENDUM

1. Definitions. These terms apply to this Addendum only.

"Covered Person" means a Covered Employee, a Covered Employee's dependent or other eligible person who is covered under the Plan.

"Health Services" means the health care services or supplies that are covered by the Plan and are received by Covered Persons.

"Network Provider" means a health care provider that has entered into an agreement with MSI, an affiliate of MSI, United HealthServices, Inc. ("UHS") or an affiliate of UHS, under which the provider has agreed to provide health care services to persons covered by health care coverage plans administered in whole or in part by MSI.

"Patient Centered Medical Home" means an approach to primary care where primary providers, families and patients work in partnership to improve quality and value in the health care system, and improve health outcomes for individuals with chronic health conditions and disabilities.

"Urgent Care Claims" means a claim for benefits if application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the claimant's life, health or ability to regain maximum function; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Plan Document Delivery.

Electronic Delivery of Plan Documents and Notices Required by Law to be Furnished under the Plan. The Plan Administrator agrees to deliver Plan Documents and Notices required by law to be furnished to Covered Employees. In accordance with Section 3.3, titled **Plan Document Drafting**, of the Administrative Services Agreement, these documents may be furnished by MSI to the Plan Administrator for delivery to Covered Employees. The Plan Administrator shall not modify these documents in any way. The Plan Administrator agrees to deliver such documents electronically to Covered Employees who meet the following requirements: (a) have the ability to access an electronic document effectively at any location where the Covered Employee is reasonably expected to perform his or her duties as an employee; and (b) with respect to whom access to the Sponsor's electronic information system is an integral part of those duties.

The Plan Administrator shall implement procedures that ensure actual receipt of these materials and notify Covered Employees of the significance of the documents at the time of delivery. In addition, the Plan Administrator shall inform the recipient of his or her right to request a paper version of these documents and an expedient process for doing so. Upon such a request, Plan Administrator shall provide the Covered Employee's mailing information to MSI so that MSI can provide the documents. MSI shall retain a record of any requests that the information be provided in writing. Plan Administrator shall inform MSI of individuals who do not qualify for electronic delivery because they do not have access to a computer as described in the preceding paragraph or they are not in the workplace, including but not limited to those individuals on continuation coverage,

on retiree coverage, or covered pursuant to a medical support order, and shall provide the individual's mailing information to MSI so that MSI can provide the documents.

3. Provider Network Access. MSI has contracted with or has access to a network of Network Providers. Some or all of those Network Providers shall be available to provide Health Services under the Plan to Covered Persons. MSI shall make the Network Provider directory available to Covered Persons by providing either a paper copy or electronic copy at the time of enrollment. In addition, access to an electronic directory is available to Covered Persons at any time on mymedica.com.

4. Claims Processing. MSI shall process or arrange for the processing of claims for Health Services under the Plan as directed by the terms of the Plan Document.

(a) Start of Plan Year.

i) Benefit Installation Documents. MSI shall provide a Summary of Benefits and Coverage and MSI Recommended Changes grid (collectively referred to as Benefit Installation Documents). Upon receipt of confirmation that Plan Sponsor agrees with the benefits as set forth in the Benefit Installation Documents, on or before a date established by MSI and communicated in advance to Plan Sponsor, MSI will install the group and begin processing claims at the benefit levels described in the Benefit Installation Documents at the start of the Contract Year.

ii) In the event Plan Sponsor does not provide such confirmation on or before the date established by MSI, MSI will install the group and begin processing claims at the benefit levels described in the Benefit Installation Documents within 10 business days of receipt by MSI.

iii) If, after, MSI has begun paying claims pursuant to agreed-upon Benefit Installation Documents, Plan Sponsor changes any benefit levels, MSI will begin processing claims at the benefit levels described in the amended Benefit Installation Documents within 10 business days of receipt by MSI. MSI will not retroactively adjust claims, unless the parties mutually agree otherwise.

(b) Claims Submission. MSI shall arrange for Network Providers to submit claims for Health Services. MSI shall provide or arrange for the provision of standard forms for the submission by Covered Person of claims for Health Services received from non-Network Providers. Plan Administrator appoints MSI a named fiduciary with respect to performing processing a payment.

(c) Claim Adjudication and Appeals.

Claim Determination and Appeals of Non-Urgent Care Claims. This section will apply to claims other than Urgent Care Claims as that term is defined in this Addendum. Plan Administrator appoints MSI a named fiduciary with respect to (i) performing claim processing and payment; (ii) performing the fair and impartial review of initial claim determinations; and (iii) performing the fair and impartial review of appeals and denied claims. With respect to these functions, Plan Administrator delegates to MSI the discretionary authority to (i) construe and interpret the terms of the Plan; and (ii) determine the validity of charges submitted to MSI under the Plan. Plan Administrator has the discretionary authority to construe and interpret the terms of the Plan and to make final, binding determinations concerning the availability of the Plan benefits.

If it is determined that the benefit is payable, MSI will issue a check for, or otherwise credit, the benefit payment to the appropriate payee. If MSI denies a Claim, the claimant shall have the appeal rights set forth in the Plan Document, and/or which are required under applicable law. MSI will process the initial appeal and determine whether a Plan benefit is available. If, after the review, MSI determines that the Plan benefit is payable, MSI will notify the claimant. If, after the exhaustion of the initial appeal with MSI, MSI determines that the Plan benefit is still not available, MSI will notify the claimant that the denial has been upheld and of their right to further appeal the denial for a second level of review. This notice will be designed to comply with MSI's standards and applicable requirements for claim denial notices. Under most circumstances, all required levels of review must be completed, described above, before proceeding to external review. External review can proceed without completing the required levels of review if MSI agrees, or if MSI fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines.

Written requests for external review may be submitted to the Commissioner of Commerce for a full and fair review which will be final and binding on MSI.

Notwithstanding the foregoing, in the event Sponsor or Plan Administrator directs MSI to reverse or modify its procedures or determination of benefits and/or the amounts of the benefits to be paid, Plan Administrator will defend, hold harmless and indemnify MSI, its officers, agents and employees against any and all claims, liabilities, damages, judgments or expenses (including reasonable attorney's fees) asserted against, imposed upon or incurred by MSI that arise out of Sponsor's or Plan Administrator's direction.

Appeals of Urgent Care Claims. Except as otherwise provided in this Addendum, Plan Administrator appoints MSI a named fiduciary under the Plan with respect to appeals of Urgent Care Claims as that term is defined in this Addendum. MSI will conduct one review of a denied Urgent Care Claim and issue a final determination as soon as possible but not later than 72 hours from receipt of the request to appeal. Plan Administrator delegates to MSI the discretionary authority to construe and interpret the terms of the Plan and to make final binding determinations concerning the availability of Plan benefits regarding these claims.

(d) **Administration of Lifetime Maximum Benefit Provisions.** This Section applies if the Plan Document contains provisions setting forth lifetime maximum benefits that apply to benefits a Covered Person receives under the Plan or has previously received under another similar benefit plan or program offered by Sponsor. It is solely the responsibility of Sponsor to obtain historical claims information from previous insurance carriers or third party administrators to support the administration of this Plan provision. MSI is not responsible for obtaining such claims information. Sponsor must provide such claims information to MSI in a format acceptable to MSI or its designee. MSI's obligation to administer such lifetime maximum benefit provisions is contingent on Sponsor's provision of acceptably formatted historical claims information to MSI. MSI is entitled to rely on the historical claims information it is provided when administering the lifetime maximum benefit provision. MSI or its designee will load such historical claims information into its claims system and begin

processing claims in accordance with such information within a reasonable time after receipt of acceptably formatted data from Sponsor.

(e) Reprocessing of Claims.

i) Historical Claims. In the event Sponsor provides MSI with historical claims data at any time after MSI initially became a third party administrator for the Plan, MSI will not re-process or make retroactive changes to previously processed claims. MSI or its designee will load the historical claims information into its claims processing system and begin processing claims in accordance with such information, including previous claims processed by MSI within a reasonable period of time after receipt of acceptably formatted claims information. In the event it is discovered that certain claims had previously been paid in excess of the lifetime maximum benefit, MSI will not re-process those claims or pursue recovery of excess amounts paid to or on behalf of Covered Persons.

ii) Plan Document Changes. MSI is not obligated to re-process any claims processed both (i) in accordance with the prior year Plan Document; and (ii) before MSI receives a new or amended Plan Document. Notwithstanding the foregoing, the parties mutually agree that MSI will conduct claims re-processing as needed as a result of any changes in the Plan Document for a fee in addition to those set forth herein.

5. Administrative Forms. MSI shall prepare and print the forms and other documents necessary for MSI to provide services under this Addendum. Notwithstanding the foregoing, if Sponsor or Plan Administrator requests customized forms or documents, other than inclusion of Sponsor's name and/or logo, Sponsor shall bear the cost of preparing and printing such forms or documents.

6. Coordination of Benefits. MSI shall conduct coordination of benefits as directed by the terms of the Plan Document. Sponsor shall provide MSI with any information in its possession regarding the existence of other coverage for a Covered Person. If a Covered Person does not provide other coverage information at the time of enrollment, MSI will notify the Covered Person that MSI requires other coverage information to process the claim. MSI shall have no obligation beyond requesting information from Covered Persons to verify the existence of other coverage. If another plan provides primary coverage for a Health Service, MSI shall direct Network Providers to first seek payment from that plan.

7. Subrogation. MSI shall provide subrogation services to the Plan Administrator. Subrogation services shall consist of identifying and seeking recovery of amounts paid by the Plan where payment was also made, or should have been made, by a third party for the same medical expense. This provision also applies to reimbursement claims against a covered party or others to obtain recovery of amounts paid by the Plan.

Sponsor grants to MSI the discretionary authority to develop and implement standards and practices relating to Plan's subrogation rights. Sponsor agrees that these standards and practices are reasonable if they are consistent with those followed by affiliates of MSI in pursuing their own subrogation rights and are generally consistent with industry practices. This grant of discretionary authority to MSI includes the authority to determine the following:

- Whether to pursue subrogation recovery; and

- What action, including litigation, should be taken to pursue recovery; and
- Whether to abandon, negotiate or compromise a claim or settle the claim for less than a full recovery.

In the exercise of this discretionary authority, MSI may initiate litigation in the name of the Plan without further consent or approval. Sponsor and Plan Administrator agree to cooperate fully with MSI in the prosecution of any litigation.

8. Utilization Management and Case Management. MSI shall perform utilization management and case management as directed by the terms of the Plan Document. MSI shall apply its standard utilization management and case management techniques to Health Services received by Covered Persons.

9. Inquiries and Complaints by Covered Persons. MSI shall respond to written or telephone requests for information made during normal business hours by Covered Persons insofar as the inquiry can be addressed under the terms of this Addendum or per the Plan Document. Notwithstanding the forgoing, the Plan Administrator is responsible for resolving complaints by Covered Persons.

10. Identification Cards. MSI shall provide identification cards to Covered Persons as set forth in the Plan Document.

11. Providing Funds for Benefits.

(a) Funds for Health Services. Sponsor hereby designates MSI as Sponsor's agent for payment to Network Providers for Health Services provided to Covered Person. MSI shall process claims of Network Providers, and such providers shall be paid according to the terms and conditions of the Plan. The fee schedules that MSI applies to Network Providers are different from the fee schedules that apply to providers who are part of networks for some of the other health coverage products offered by MSI and MSI affiliates. If MSI processes claims of non-Network Providers such providers shall be paid according to the terms and conditions of the Plan Document and as set forth in Exhibit 5.2. If a dispute arises between Sponsor and any provider regarding payment of a claim, MSI shall use reasonable efforts to facilitate resolution of the dispute.

Payment from General Assets of Sponsor. Sponsor shall use funds from its general assets to make payments for Health Services and fees to MSI. Sponsor shall not set up a trust or an account in the Plan's name to be used to pay for Health Services or fees to MSI.

(b) Funds Available. Upon the Effective Date of this Addendum, Sponsor shall (a) maintain a bank account that holds general assets of Sponsor upon which MSI shall have check writing authority to make payments for Health Services and fees to MSI; or (b) maintain a bank account that holds general assets of Sponsor and give MSI the right to initiate automated clearinghouse ("ACH") transfers from such account to make payments for Health Services and fees to MSI; or (c) establish some other method of payment of such claims and fees as is mutually agreeable to both parties.

(c) Transfers of Funds. As medical claims are processed for each time period, MSI shall, 48 hours after notice to Sponsor, exercise check writing authority upon Sponsor's account or initiate ACH transfers from Sponsor's account in an amount necessary to pay the claims processed and fees due MSI. MSI shall communicate each amount paid from Sponsor's account via telephone, facsimile

or other electronic means as approved by the parties to Sponsor, and shall transfer such amount to an account in MSI's name. Sponsor acknowledges and agrees that the account into which MSI transfers funds received from Sponsor may contain money from one or more other health plans under contract with MSI for administrative services.

(d) **Payments to Providers.** MSI shall pay providers as agent of Sponsor within 2 days of receipt of Sponsor's funds. Sponsor acknowledges that MSI shall therefore hold such funds for only 2 days at most before distributing them to providers in payment for Health Services. The parties anticipate that any and all interest earned on Sponsor's funds while in an MSI account shall be de minimis, and Sponsor agrees that MSI shall be entitled to retain such interest as part of the aggregate administrative fees paid to MSI for the provision of services under this Addendum. Interest amounts retained by MSI under this Section shall be in addition to the other amounts set forth in the Administrative Services Agreement as payment for MSI's administrative services and shall therefore not be considered as payment or partial payment of such other amounts.

(e) **Invoices.** MSI shall forward to Sponsor: (i) a report itemizing amounts payable for Health Services during that period; (ii) an invoice summarizing the claims charges payable for the period and any additional fees due MSI as set forth in Exhibit 5.2; and (iii) a report setting forth administrative fees due MSI. MSI shall adjust any claim disputes by Sponsor, or errors detected by MSI or Sponsor, in the supporting reports for the next period's payment due after the dispute is resolved or errors identified.

(f) **Underfunding.** If Sponsor does not make funds available to pay claims and fees in the required amount and Sponsor fails to provide the required amount of funds within 48 hours after notice of the need to provide such funds, MSI may immediately terminate this Addendum and its obligations under this Addendum. If MSI terminates this Addendum, as provided in this Section, MSI shall provide notice of such termination to Network Providers. The Network Providers may then bill Sponsor, the Plan and/or Covered Persons directly for such Health Services. Additionally, in the event Sponsor fails or delays in making funds available for claims payment in accordance with the terms of this Section and such failure or delay results in interest due to health care providers under applicable prompt pay laws and/or regulations, such interest shall be the sole responsibility of Sponsor, and Sponsor shall hold harmless and indemnify MSI from liability for any and all such interest payments.

(g) **Run Out.** When this Addendum terminates, the funding method for Plan benefits will remain in place for six (6) months following the end of the Contract Year. The fees for performing these services are set forth in Exhibit 5.2.

12. **Part D Creditable Coverage Notices.** MSI shall distribute, on behalf of Sponsor, the annual and ongoing Part D creditable coverage notices as required under 42 CFR 423.56(f)(1)-(4), as amended. For those notices that must be distributed to Medicare eligible individuals prior to the effective date of coverage in the Plan, Sponsor must determine whether such individuals should receive such a notice, and MSI will provide copies of notices to Sponsor for inclusion in and distribution by Sponsor in pre-sale and member packet materials. All other notices will be mailed to Covered Persons.

13. **My Health Rewards Program.** MSI will provide a standard value-based benefit program that emphasizes member engagement and personalization. The program is

based on a behavior-based model that encourages and motivates members to make better health care decisions. Each Covered Person (18 years of age and older) is eligible to earn points for MSI incentives. Program components are subject to modification from time to time.

EXHIBIT 2.6(f)

BUSINESS ASSOCIATE AGREEMENT

Terms used in this 2.6(f), but not otherwise defined in this Business Associate Agreement, shall have the meaning set forth in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§17921-17954, ("ARRA"), as each is amended from time to time. For purposes of this Business Associate Agreement, MSI shall identify the records in its possession that are components of a Designated Record Set and shall consider those records as a Designated Record Set in satisfying its obligations under this Business Associate Agreement. MSI shall make such determination in accordance with 45 C.F.R. § 164.501.

1. Obligations and Activities of MSI. MSI agrees to:

(a) not use or further disclose Protected Health Information ("PHI") other than as permitted or required by this Business Associate Agreement, the Agreement or as otherwise Required By Law;

(b) limit its uses and disclosures of PHI, including disclosures to the Plan Administrator, to the minimum necessary PHI needed to perform the functions, activities, or services provided for by the Agreement;

(c) use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Business Associate Agreement, the Agreement or as Required By Law;

(d) report to the Plan Administrator any use or disclosure of PHI not provided for by this Business Associate Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410;

(e) ensure that any Subcontractor to whom it provides PHI received from, or created, received, transmitted, or maintained by MSI on behalf of, the Plan Administrator agrees in writing to the same restrictions and conditions that apply through this Exhibit 2.6(f), Business Associate Agreement, to MSI with respect to such information;

(f) provide access to PHI in a Designated Record Set to an Individual in accordance with 45 C.F.R. § 164.524. In the event an Individual requests a copy of PHI maintained electronically in one or more Designated Record Sets, MSI agrees to provide access, at the request of the Plan Administrator, to the Individual to such PHI in an electronic form and format.

(g) make any amendment(s) to PHI in a Designated Record Set that the Plan Administrator directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of the Plan Administrator or an Individual, in order to meet the requirements under 45 C.F.R. § 164.526;

(h) make available all records, books, and policies and procedures relating to the use and/or disclosure of PHI received from, or created, received, maintained or transmitted by MSI on behalf of, the Plan to the Secretary of HHS ("Secretary"), in a time and manner designated by the Secretary, for purposes of determining the Plan's compliance with the HIPAA privacy regulation, subject to the attorney-client and other applicable legal privileges;

(i) document such disclosures of PHI and information related to such disclosures by MSI as would be required for the Plan Administrator to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528;

(j) provide to the Plan Administrator or an Individual, in accordance with 45 C.F.R. § 164.528, information collected in accordance with Section 1(i) above, to permit the Plan Administrator to respond to a request for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. MSI shall provide an accounting of disclosures in accordance with this section and as required by 42 U.S.C. § 17935 if PHI is contained in an Electronic Health Record;

(k) upon request, provide to the Plan Administrator a draft notice of privacy practices for the Plan Administrator's review and consideration. Notwithstanding the foregoing, the Plan Administrator is solely responsible for the final content of the Plan's notice of privacy practices, for adopting such notice in final form, and for providing notice to Individuals as required by the HIPAA privacy regulation. MSI shall provide services under the Agreement in a manner consistent with any and all policies and processes set forth in the draft notice of privacy practices provided by MSI; and

(l) in accordance with the security regulations, 45 C.F.R. Part 142, as amended from time to time, MSI agrees to comply with the security regulations and to:

i) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

ii) ensure that any Subcontractor to whom it provides electronic PHI agrees in writing to implement reasonable and appropriate safeguards to protect it;

iii) report to the Plan Administrator any Security Incident of which it becomes aware;

iv) authorize termination of this Business Associate Agreement and the Agreement if the Plan Administrator determines that MSI has violated a material term of this Business Associate Agreement;

v) agree to amend and incorporate such amendments as necessary to this Business Associate Agreement to comply with changes to HIPAA, including the security regulations.

(m) with respect to any use or disclosure of Unsecured PHI not permitted by HIPAA that is caused solely by MSI or its Subcontractor's failure to comply with one or more of its obligations under this Business Associate Agreement, the Plan Administrator hereby delegates to MSI the responsibility for determining when any such incident is a Breach and for providing all legally required notifications to Individuals, HHS and/or the media, on behalf of the Plan Administrator. MSI shall provide these notifications in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective compliance dates, and shall pay for the reasonable and actual costs associated with such notifications. In the event of a Breach, without unreasonable delay, and in any event no later than sixty (60)

calendar days after discovery, MSI shall provide the Plan Administrator with written notification that includes a description of the Breach, a list of affected Individuals (unless the Plan Administrator is a plan sponsor ineligible to receive PHI) and a copy of the template notification letter sent to Individuals;

(n) not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d);

(o) not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a);

(p) not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b); and

(q) comply with any and all privacy regulations that apply to the Plan in the performance of a Plan obligation, to the extent MSI is to carry out a Plan obligation under such privacy regulations.

2. Permitted Uses and Disclosures of PHI.

(a) Except as otherwise limited in this Business Associate Agreement, MSI may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Plan as specified in the Agreement, provided that such use or disclosure would not violate the HIPAA privacy regulation if done by the Plan or the Plan Administrator on the Plan's behalf and is in compliance with each applicable requirement of 45 C.F.R. § 164.504(e) and the privacy requirements referenced in HIPAA.

(b) Except as otherwise limited in this Business Associate Agreement, MSI may use PHI for the proper management and administration of MSI or to carry out MSI's legal responsibilities.

(c) Except as otherwise limited in this Business Associate Agreement, MSI may disclose PHI for the proper management and administration of MSI or to carry out MSI's legal responsibilities, provided that (i) the disclosures are Required By Law; or (ii) MSI obtains reasonable assurances from the recipient that the PHI will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the recipient, and the recipient notifies MSI of any instances of which it is aware in which the confidentiality of the information has been breached.

(d) Except as otherwise limited in this Business Associate Agreement, MSI may use PHI to provide Data Aggregation services to the Plan as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(e) MSI may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(1).

3. Obligations of the Plan Administrator. In addition to other obligations under HIPAA:

(a) The Plan Administrator shall notify MSI of any provisions that the Plan proposes to adopt in its notice of privacy practices that differ from the draft privacy notice provided to the Plan Administrator by MSI or that may limit MSI's use or disclosure of PHI beyond the restrictions set forth in this Business Associate Agreement. MSI will only be required to comply with such different or additional restrictions upon its specific written agreement to do so, which MSI may grant or withhold in its sole discretion. If MSI's performance under this Business

Associate Agreement will be made materially more burdensome or expensive due to such new restrictions, the parties shall negotiate an appropriate adjustment to the fee paid to MSI.

(b) The Plan Administrator shall notify MSI of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect MSI's permitted or required uses and disclosures.

(c) The Plan Administrator shall notify MSI of any request for a restriction on the use or disclosure of PHI that the Plan Administrator receives in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect MSI's use or disclosure of PHI, MSI will only be required to comply with such request upon its specific written agreement to do so, which MSI may grant or withhold in its sole discretion. If MSI's performance under this Business Associate Agreement will be made materially more burdensome or expensive due to such restriction, the parties shall negotiate an appropriate adjustment to the fee paid to MSI.

(d) The Plan Administrator shall not request MSI to use or disclose PHI in any manner that would not be permissible under HIPAA if done by MSI. An exception shall be if MSI will use or disclose PHI for Data Aggregation or management and administrative activities of MSI.

4. **Disclosures to Plan Sponsor.** MSI may provide to Sponsor, in its capacity as Sponsor, only aggregate data and other reasonably requested information that does not identify either services received by or the medical condition of individual Covered Employees, and that is not otherwise "Protected Health Information" or ("PHI") as that term is defined under HIPAA. However, if the data or information requested identifies either services received by or the medical condition of an individual Covered Employee, or is otherwise PHI, then release by MSI to Sponsor is subject to the following:

(a) **Plan Document Revisions.** The Plan Administrator acknowledges that the HIPAA privacy regulation, at 45 CFR 164.504(f)(2), requires certification of amendment of plan documents for a group health plan that is a covered entity under HIPAA as a condition to disclosure of PHI to the applicable plan sponsor. Plan Administrator and Sponsor warrant that neither shall request MSI to disclose PHI to Sponsor unless the Plan Documents have been appropriately amended and any required certification to that effect has been provided to Plan Administrator.

(b) **Termination.** Upon termination of the Administrative Services Agreement, MSI shall return or destroy all PHI received from the Plans, or created or received by MSI on behalf of the Plans. This provision shall apply to PHI that is in the possession of subcontractors or agents of MSI. MSI shall retain no copies of PHI. Notwithstanding the foregoing, in the event that MSI determines that returning or destroying the PHI is infeasible, MSI shall be entitled to retain such PHI, provided that MSI shall extend the protections of this Exhibit 2.6(f) of this Agreement to such PHI and limit further uses and disclosures to those purposes that make the return or destruction infeasible, for so long as MSI maintains such PHI.

EXHIBIT 5.2

FEES

The terms of this Exhibit 5.2 shall apply to the Contract Year commencing January 1, 2016 and ending December 31, 2016.

1. Definitions. These terms apply to this Addendum only.

(a) **"Copayment, Coinsurance and/or Deductible Amounts"** means the portion of Provider Billed (Retail) Amounts (net of other Disallowed Charges) paid by the Covered Employee directly to the provider. Copayment, Coinsurance and/or Deductible Amounts are calculated pursuant to the terms of the applicable Plan Document.

(b) **"Disallowed Charges"** means the portion of the Provider Billed (Retail) Amounts that are ineligible for coverage and not paid by Sponsor to the provider. The Disallowed Charges are identified to Sponsor by MSI through claim payment edits that are designed to detect coordination of benefits, duplicate claims or other ineligible benefits or provider charges. Some portion of Disallowed Charges may be the Covered Employee's responsibility, pursuant to the terms of the applicable Plan Document.

(c) **"Non-Network Provider"** means a provider not under contract as a Network Provider.

(d) **"Non-Network Provider Reimbursement Amount"** means the amount of payment to a Non-Network Provider for Health Services.

(e) **"Provider Billed (Retail) Amounts"** means the prices or fees established by a provider and uniformly billed by the provider, without regard to negotiated discounts for Health Services delivered to Covered Persons.

2. Fees Payable by Sponsor to MSI.

(a) Sponsor shall pay MSI a fee for administrative services equal to 1.90% of the full amounts payable by the Sponsor to MSI pursuant to Section 3 of this Exhibit 5.2, including any amounts subject to reimbursement pursuant to Sponsor's agreement for stop loss insurance. Upon termination of this Agreement, during the period MSI is paying incurred but not reported health plan claims, Sponsor shall pay one hundred percent (100%) of this fee for the six (6) months after termination.

(b) Sponsor shall also pay MSI $2.43 per Covered Employee for each month or part of a month covered by this Agreement for management services related to Health Services received from Network Providers. Upon termination of this Agreement, during the period MSI is paying incurred but not reported claims, Sponsor shall pay one hundred percent (100%) of this fee for the six (6) months after termination.

(c) MSI may arrange for a subcontractor to perform any of the subrogation services. Sponsor agrees that the fee charged by MSI or a subcontractor associated with pursuing subrogation shall be deducted from any recovery. The fee charged by MSI or the subcontractor for the current contract year is 23.5% of any recovery. Any subrogation recovery shall be forwarded to Sponsor's general account or

credited to Sponsor's claims account. No such amount shall be considered to be a Plan asset.

(d) The fees for broker services, which shall be paid out of Sponsor's general assets, are as follows:

10.0% of both the specific and aggregate premium billed for stop-loss coverage. These amounts are built into the amounts billed for stop-loss coverage.

MSI will remit broker fees, if applicable, to the broker that has provided services in relation to this Agreement.

(e) **My Health Rewards.** The fee for the My Health Rewards program is included as part of the administration fee indicated in (a) in this section.

(f) **Payment for Health Management Program Services.** Sponsor shall, within 30 days of receipt of a quarterly invoice from MSI, pay the fees for health management program services as follows:

After calculating the quarterly group utilization and enrollment for each Affiliated Health Club, MSI shall bill Sponsor up to $21.25 (for 8 visit requirement) per month for each credit up to a $20.00 credit made toward the payment of Covered Persons' health club dues. Of the amounts collected from Sponsor, MSI shall remit up to $20.00 for each up to $20.00 credit issued to the various Affiliated Health Clubs.

Failure to remit the amount set forth above will result in termination of the health management program services, and may result in termination of the Agreement between the parties.

(g) **In the event Sponsor or Plan Administrator requests MSI to provide services that differ materially from those described in this Agreement or an Addendum, the additional cost of such services shall be paid by Sponsor at MSI's then-current rates and out-of-pocket expenses.**

3. Health Services Payments by Sponsor to MSI.

(a) Network Provider Physician and Allied Professional Health Services

Amounts paid for Health Services as established by the terms of the Network Provider Agreement with MSI, less any Copayment, Coinsurance and/or Deductible Amounts. Payment to providers to provide Patient-Centered Medical Homes will be in addition to claims for medical services. Providers associated with care coordination are subject to statistical evaluation to assess the impact of the patient-centered medical home on clinical outcomes, patient experience and cost. Care coordination fees will be prospectively adjusted accordingly.

(b) Network Provider Inpatient Hospital and Ancillary Facility Health Services

Amounts paid for Health Services as established by the terms of the Network Provider Agreement with MSI, less any Copayment, Coinsurance and/or Deductible Amounts.

(c) Network Provider Outpatient Hospital and Ancillary Facility Health Services

Amounts paid for Health Services as established by the terms of the Network Provider Agreement with MSI, less any Copayment, Coinsurance and/or Deductible Amounts.

(d) Network Provider Mental Health and/or Substance Abuse Health Services

Amounts paid for Health Services as established by the terms of the Network Provider Agreement with MSI, less any Copayment, Coinsurance and/or Deductible Amounts.

(e) Network Provider Pharmacy Health Services

The amount paid for Health Services as established by the terms of the Network Provider Agreement with MSI, which is estimated to be the least of (1) the average wholesale price ("AWP") for such pharmaceutical product, less discounts that generally range between 10% and 16%; (2) the maximum allowable cost for such pharmaceutical product ("MAC"); or (3) the ingredient or product cost billed by the Network Provider, in each case plus a dispensing fee and less any Copayment, Coinsurance and/or Deductible. MSI's estimate of its cost for Network Provider Pharmacy Health Services, set forth above, does not include a reduction for any rebates that might result from Health Services to Covered Persons. To the extent that MSI receives credit for any rebates, such credits are reflected in the administrative fee set forth in Section 2(a) above. MSI estimates that for the Contract Year referenced in this Exhibit 5.2, MSI will receive pharmacy rebates in an amount approximating 1% of aggregate amounts billed by MSI to certain plan sponsors for Health Services discussed in Items 3(a)-3(f). For purposes of this paragraph, "certain plan sponsors" refers to all plan sponsors who have entered into administrative services agreements with MSI for such Contract Year and who are providing pharmacy benefits to Covered Persons. Sponsor is such a plan sponsor. From time to time, MSI or an intermediary may negotiate with drug manufacturers regarding the payment of Medical Benefit Rebates on applicable prescription drugs dispensed to Covered Persons under the Plan's medical benefit.

(f) Non-Network Providers

Pursuant to the terms of the applicable Plan Document, the Non-Network Provider Reimbursement Amount is:

i) For claims for hospital benefits, the lesser of a) the Provider Billed (Retail) Amount; or b) the amount that the provider and MSI have agreed upon; in either case less any Copayment, Coinsurance and/or Deductible Amounts.

ii) For claims for non-hospital benefits, the lesser of a) the Provider Billed (Retail) Amount; or b) the amount MSI determines appropriate, with such determination based on marketplace charges for similar services and supplies in the geographic area in which the benefit is provided; in either case less any Copayment, Coinsurance and/or Deductible Amounts.

MSI shall be entitled to an additional fee in consideration for MSI's services in establishing, maintaining and operating a Network Provider network. Such fee shall be approximately equal to or less than 3.8% of the sum of (1) the amounts billed to Sponsor by MSI for Health Services identified in Items 3(a), 3(b), 3(c) and 3(d) above and (2) Copayment, Coinsurance and/or Deductible Amounts paid for Health Services identified in Items 3(a), 3(b), 3(c) and 3(d) above. Amounts billed to Sponsor by MSI for Health Services identified in Items 3(a), 3(b), 3(c) and 3(d) above shall be the total of (1) such fee, and (2) amounts paid to such Item 3(a), 3(b), 3(c) and 3(d) Network Providers by MSI. Upon

termination of this Agreement, during the period MSI is paying incurred but not reported claims, Sponsor shall pay one hundred percent (100%) of this fee.

(g) **Alternative Provider Payment Methodologies.** Network Provider contracts may include incentives earned as a condition of meeting standards relating to utilization, quality of care, efficiency measures, compliance with other initiatives (such as patient-centered medical homes), or other clinical integration or practice transformation standards. An example of such alternative arrangements includes Network Provider contracts using a risk pool. The Network Provider will be paid a negotiated amount and a portion of that Health Services payment, as negotiated with Network Providers is placed at risk to be returned if certain standards are not met. As compensation for negotiating, designing and measuring standards with Network Providers, MSI will retain any amounts Network Providers are required to return to MSI for failure to meet standards. MSI anticipates that such amounts will not exceed one percent (1%) of claims. Sponsor agrees that MSI shall be entitled to retain such amounts as part of the aggregate administrative fees paid to MSI for the provision of services under this Addendum. Plan Administrator agrees and understands that the Network Provider will retain these at-risk amounts and the interest earned on such amounts will be retained by the Network Provider as part of the Health Services fee arrangement. Due to the comprehensive nature of such measures, final determination of meeting criteria may not occur until subsequent plan years.

MSI reserves the right to use different alternative payment methodologies than the risk pool method described here. In the event MSI enters into other arrangements which would result in a portion of the Health Services payments made under this Section 3 potentially not being earned by Network Providers, MSI will provide information to Plan Administrator regarding the arrangement.

Only the initial Health Services payment to Network Providers will be subject to a Covered Employee or Dependent's Copayment, Coinsurance and/or Deductible Amounts. Subsequent return of a risk pool amount, although attributable to the covered services rendered by the Network Provider during the measurement period, will generally not give rise to a second coinsurance obligation or deductible liability for, or refund to, the Covered Employee or Dependents who received the original covered services.

STOP LOSS INSURANCE CONTRACT

BETWEEN

SIBLEY/MCLEOD COUNTY

AND

MEDICA INSURANCE COMPANY ("MIC")

EFFECTIVE
JANUARY 1, 2016

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ARTICLE 1

STOP LOSS SCHEDULE

Employer Name: Sibley/McLeod County
Employer Group Number(s): 45192, 45193, 45799, 45957, 45958, 53052, 53053, 53441, 80046-80053
Contract Period begins on: January 1, 2016 and ends on: December 31, 2016
Claims Administrator: Medica Self-Insured

1. Specific Stop Loss Insurance

   a. Specific deductible:
   $125,000 per Covered Person for all occurrences.

   b. MIC's limits of liability:
   Out-of-network benefits: $875,000
   Maximum reimbursement per Covered Person per lifetime.

   c. Monthly Premium rate

Covered Unit	Rate
Single	$70.92
Family	$200.44

   d. Claims Basis:
   Claims Incurred in Contract Period, or during 12 months prior to Contract Period; and Claims paid in Contract Period, or incurred in Contract Period and paid within 3 months after end of Contract Period.

2. Aggregate Stop Loss Insurance

   a. Aggregate Liability

	Benefit Plan 1	Benefit Plan 2
Covered Unit	Monthly Factor	Monthly Factor
Single	$756.90	$563.85
Family	$2,085.63	$1,547.06

	Benefit Plan 3	Benefit Plan 4
Covered Unit	Monthly Factor	Monthly Factor
Single	$549.75	$688.78
Family	$1,514.79	$1,897.92

	Benefit Plan 5	Benefit Plan 6
Covered Unit	Monthly Factor	Monthly Factor
Single	$513.10	$500.27
Family	$1,407.82	$1,378.46

   b. Minimum aggregate deductible:
   $3,436,765.

   c. MIC's limit of liability:
   $1,000,000 maximum aggregate reimbursement for all Covered Persons per Contract Period.

Any reimbursement payable by MIC under the Specific Stop Loss Insurance shall not be reimbursed again under the Aggregate Stop Loss Insurance and cannot be used in calculating payments toward the aggregate deductible.

d. Premium: $3.23 paid per Enrollee per month.

e. Claims Basis:
Claims Incurred in Contract Period, or during 12 months prior to Contract Period; and Claims paid in Contract Period, or incurred in Contract Period and paid within 3 months after end of Contract Period.

f. Monthly Accommodation: No

ARTICLE 2

DEFINITIONS

For purposes of this Contract, the following terms shall have the meanings set forth below:

Administrative Services Agreement – the Administrative Services Agreement between Employer and Medica Self-Insured.

Claims Administrator – the entity identified in the Stop Loss Schedule, which has been selected by Employer to process claims under the Plan Document. Employer shall not assign any of its rights and responsibilities under this Contract to any person or entity without the prior written consent of MIC, which consent shall not be unreasonably withheld.

Claims Invoice – the weekly document that details the claims which have been processed and will be paid in the immediately following week.

Contract – the contractual agreement between MIC and Employer which consists of this Stop Loss Insurance Contract and any properly attached exhibits and amendments.

Contract Anniversary – the date the Contract Period begins as set forth in the Stop Loss Schedule.

Contract Period – the period of time specified in the Stop Loss Schedule. Contract Period also means any fraction of the period if the Contract terminates before the end of the period as specified in the Stop Loss Schedule.

Covered Person – an employee of Employer, their dependent or other eligible person who is covered under the Plan Document.

Covered Unit – an employee of Employer or an employee with dependents, as identified in the Stop Loss Schedule.

Eligible Expenses – the total amounts paid by Employer as Health Services payments under the Administrative Services Agreement, excluding those amounts paid on a capitated basis. An Eligible Expense is considered to be incurred on the date a service is performed or supply is purchased.

Employer – the employer or other group to whom MIC has issued this Contract.

Health Services – the health care services or supplies that are covered by the Plan and are received by Covered Persons.

Plan – that plan of health care coverage established by Employer for its employees, their dependents or other eligible person, as in effect on the Effective Date of this Contract.

Plan Document – Employer's self-insured or self-funded health care plan which governs the administration of benefits and provides for the benefit of its Covered Persons.

Premium Due Date – (a) for the Specific Stop Loss Insurance, the 15th day of each month; and (b) for the Aggregate Stop Loss Insurance, the 15th day of each month, or as otherwise specified in the Stop Loss Schedule.

Stop Loss Schedule – the schedule shown in Article 1 of this Contract.

Substantial Change – a change in the Employer's circumstances that MIC reasonably determines is material to the terms of this Contract, including, but not limited to: (i) Employer's acquisition or termination of a business unit; (ii) a significant increase or decrease in the number of Covered Units and/or Covered Persons; (iii) any changes to the Plan; and (iv) situations where the Eligible Expenses paid in the last 2 months of the preceding Contract Period vary by more than 10% of the average monthly Eligible Expenses paid during the prior 10 months.

ARTICLE 3

COVERAGE UNDER THIS CONTRACT

Medica Insurance Company ("MIC") agrees to provide coverage under the provisions of this Stop Loss Insurance Contract for the Employer, an employer under Minnesota law and other applicable law.

While the stop loss insurance under this Contract is in force, MIC shall provide the coverage specified in the Stop Loss Schedule subject to the terms and conditions of this Contract. This coverage is in consideration of the Employer's request for coverage and payment of premiums when due. A separate Stop Loss Schedule applies for each Contract Period that this Contract is in force.

In the event stop loss insurance coverage becomes payable, subject to all of the terms and conditions of this Contract, MIC shall reimburse Employer the amount of Eligible Expenses Employer has paid which exceed the applicable deductible specified in the Stop Loss Schedule.

ARTICLE 4

SPECIFIC STOP LOSS INSURANCE

Section 4.1 Claim Basis. A specific deductible applies to each Covered Person every Contract Period. The specific deductible is satisfied by payments Employer has made for Eligible Expenses for each Covered Person. Eligible Expenses are those claims:

a. incurred in Contract Period, or during 12 months prior to Contract Period; and

b. paid in Contract Period, or incurred in Contract Period and paid within 3 months after end of Contract Period.

There is no coverage for payments Employer makes: (i) which have already been reimbursed by MIC or another insurance company or reinsurance company (as stated in Article 10); or (ii) after the Specific Stop Loss Insurance terminates. Eligible Expenses for a Contract Period do not include amounts that are paid in the first three months of the Contract Period but which were incurred in the twelve months prior to the Contract Period and included as Eligible Expenses for the prior Contract Period.

If the Contract terminates during the Contract Period, the Specific Stop Loss Insurance will be determined as if the Contract had remained in effect for the entire Contract Period.

MIC may change the specific deductible for this Contract Period, retroactive to a Contract Anniversary, if it determines there has been a Substantial Change. If Employer does not agree to this modification, it shall have the right to terminate this Contract upon 30 days' written notice to MIC.

Section 4.2 Benefit Payment. Benefits for Specific Stop Loss Insurance shall be paid by MIC upon its receipt and acceptance of proof of loss submitted by Employer or Claims Administrator. Payment shall be made in the manner determined by MIC, as an adjustment to the Claims Invoice directly by check or as administrative adjustment to an account held by MIC on Employer's behalf in accordance with the Administrative Services Agreement. MIC shall have sole authority to pay or deny claims which exceed the specific deductible stated in the Stop Loss Schedule.

ARTICLE 5

AGGREGATE STOP LOSS INSURANCE

Section 5.1 Effect of Specific Stop Loss Insurance on Aggregate Stop Loss Insurance. Any reimbursement payable by MIC under the Specific Stop Loss Insurance shall not be reimbursed again under the Aggregate Stop Loss Insurance and cannot be used in calculating payments toward the aggregate deductible. Only payments made by Employer which are used to satisfy a specific deductible amount shall be used to meet the aggregate deductible.

Section 5.2 Claim Basis. An aggregate deductible applies each Contract Period as determined in Section 5.3. Subject to Section 5.1, the aggregate deductible is satisfied by payments Employer has made for Eligible Expenses for all Covered Persons. Eligible Expenses are those claims:

a. incurred in Contract Period, or during 12 months prior to Contract Period; and

b. paid in Contract Period, or incurred in Contract Period and paid within 3 months after end of Contract Period.

There is no coverage for payments Employer makes: (i) which have already been reimbursed by another insurance company or reinsurance company (as stated in Article 10); or (ii) after the Aggregate Stop Loss Insurance terminates. Eligible Expenses for a Contract Period do not include amounts that are paid in the first 3 months of the Contract Period but which were incurred in the 12 months prior to the Contract Period and included as Eligible Expenses for the prior Contract Period.

Section 5.3 Contract Period Aggregate Deductible Determination. The aggregate deductible is determined as the greater of:

a. The minimum aggregate deductible specified in the Stop Loss Schedule; or

b. The monthly aggregate deductible calculated by multiplying the number of Covered Units whose effective date falls on or before the first of that month by the monthly factors specified in the Stop Loss Schedule. During a strike, lock-out or work stoppage, the number of Covered Units shall remain the same number as for the month before the work disruption began.

MIC may change the aggregate monthly factors used to determine the Aggregate Stop Loss Insurance for this Contract Period, retroactive to a Contract Anniversary, if it determines there has been a Substantial Change. If Employer does not agree to this modification, it shall have the right to terminate this Contract upon 30 days' written notice to MIC.

Section 5.4 Benefit Payment. Benefits for Aggregate Stop Loss Insurance shall be paid by MIC within 45 days of the end of each Contract Period after its receipt and acceptance of proof of loss submitted by Employer or Claims Administrator. MIC shall have sole authority to pay or deny claims which exceed the aggregate deductible as determined in Section 5.3.

ARTICLE 6

CLAIM PROVISIONS

Section 6.1 Claims Under the Plan Document. It is Employer's responsibility, either directly or through the Claims Administrator, to perform the claims function for the Plan Document and to audit, calculate and pay benefits covered by the Plan Document. No one, including Employer, shall process claims for the Plan Document unless named as the Claims Administrator. MIC shall not reimburse Employer for benefits processed by someone other than the Claims Administrator.

Section 6.2 Audit. MIC shall have the right to inspect and audit any claims paid under the Plan Document in the event that stop loss insurance coverage becomes payable under this Contract. Employer must provide MIC with any information MIC may require for proof of payment and all reasonable and necessary information and records in the event of a claim under this Contract.

ARTICLE 7

RECORDS AND REPORTS

Section 7.1 Records and Review. Any release of records or access to records under this Section 7.1 is subject to the confidentiality provision at Section 7.3.

MIC shall maintain records relating to its responsibilities under this Contract and shall provide to Employer records requested by Employer as provided herein. Plan administrator shall maintain records relating to the terms and operation of the Plan, including the identification of eligible persons, financial arrangements with the Claims Administrator and payments for Eligible Expenses.

Each party may have access to the records directly relating to the Plan and maintained by the other party during normal business hours and upon reasonable notice, provided, however, that MIC shall not be required to disclose proprietary or confidential business information. The party requesting records shall pay the cost of photocopying. The party inspecting or auditing records shall pay (i) the party holding such records at the standard rate for personnel time expended in connection with complying with the inspection or audit, to the extent such personnel time exceeds 24 hours, and (ii) any other costs incurred in complying with the audit or inspection request.

The right of either party to audit the records of the other shall relate solely to the application of the terms of this Contract. Any audit performed pursuant to this Section 7.1 shall be conducted by a third party to be mutually agreed upon by the parties. The third party shall execute a confidentiality agreement as required by the party releasing the information. The request for an audit or inspection must be given within 12 months after termination of this Contract. In no event shall any audit or inspection include records dated more than 3 years before the request.

Employer acknowledges and agrees that, on behalf of itself and the Plan, MIC may use and transfer to third parties for purposes of research and analysis the claims and related medical data in MIC's possession. The parties shall maintain the confidentiality of any information

relating to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without the prior written consent of that party. The provisions of this paragraph shall survive the termination of this Contract.

It is the plan administrator's responsibility to maintain all records on behalf of the Plan. However, in the event of the termination of this Contract, MIC shall provide Employer with copies of records in MIC's possession relating to the Plan and necessary for the continued operation of the Plan. The copies may be provided in hard copy or machine readable form, at MIC's discretion. All records generated or maintained by MIC as necessary for MIC to provide administrative services relating to the Plan shall be kept for 8 years after the date the records were created or any applicable period required by law, whichever is longer.

Section 7.2 Reports. Any provision of reports under this Section 7.2 is subject to the confidentiality provision at Section 7.3.

Employer must maintain, or arrange for Claims Administrator to maintain, adequate records and provide any information required by MIC to administer this Contract, including a monthly status report on a form designated by MIC, furnished within 30 days after the end of each month, and preliminary notification when Employer's payments reach 50% of a deductible. MIC may periodically examine and make copies of any of Employer's records which have a bearing on MIC's obligations under this Contract or any claims filed under the Plan Document. Such records shall be open to MIC for inspection during normal business hours for up to five years after termination of this Contract.

In the event MIC requests that Employer provide information other than information contained in the reports listed above, Employer shall be responsible for obtaining written authorizations from Covered Persons to release such information and shall forward such written authorizations to MIC. Employer shall provide additional information upon receipt of the required authorizations.

Section 7.3 Confidentiality. MIC may provide to Employer reasonably requested information, including that described in Sections 7.1 and 7.2, that does not identify either services received by or the medical condition of individual Covered Persons. However, if the data or information requested identifies either services received by or the medical condition of an individual Covered Person, then release by MIC to the Employer is subject to the following:

a. **Valid Consent.** If Employer obtains a valid written authorization, acceptable to MIC, from the Covered Person to release identifiable information to the Employer and forwards such authorization to MIC, then MIC may release identifiable information to Employer. Valid consent must comply with applicable federal and state laws, including the federal regulations governing release of alcohol or substance abuse treatment records.

b. **Acceptable Request from Employer.** MIC may release identifiable information to Employer only to report claims experience or for Employer's use in conducting an audit, if the information disclosed is reasonably necessary for Employer to conduct a review or audit. MIC may also release identifiable information to Employer related to Covered Persons' appeals of claims denials, if the information disclosed is reasonably necessary for Employer to resolve the Covered Person's appeal.

Employer shall make a request to MIC in writing describing to whom the information should be released, for what purposes, and what types of information are requested. Employer shall only use the requested information for the purposes it stated to MIC in its written request. Employer shall not disclose such information to third parties unless such disclosure is made pursuant to valid consent given by the individual(s) to whom the information pertains or as allowed or required by applicable law. This agreement to hold such information confidential shall also be

binding on plan administrator, all directors, officers, employees, agents, successors and assigns of Employer. Employer shall indemnify and hold MIC harmless from and against any and all claims, liabilities, obligations, damages and expenses resulting from Employer's request for, use of, and disclosure of such information.

Section 7.4 Release to Agents. Upon the written request of Employer, information shall be released to an agent of Employer subject to the terms of this Section and only if such agent executes a confidentiality agreement in a form satisfactory to MIC. Employer may elect to appoint an insurance broker as its agent, but in the absence of such an appointment an insurance broker shall be considered a third party and not part of Employer for purposes of receipt of information under this Article 7.

ARTICLE 8

LIABILITY AND INDEMNIFICATION

MIC's obligation to provide coverage under this Contract is limited to indemnifying Employer for Eligible Expenses in accordance with the terms and conditions of this Contract. None of the following shall be considered Eligible Expenses and such charges shall be the sole responsibility of Employer:

a. Any costs Employer incurs because of any disputes or contested claims under the Plan Document.

b. Any punitive, exemplary, extra-contractual or consequential damages or other costs or expenses of any kind, including reasonable attorney fees incurred in defending claims or lawsuits brought against MIC by a Covered Person.

c. Any fees for Employer's participation in any insolvency, guarantee or similar fund.

d. Any premium tax assessed against MIC in amounts greater than the cost to Employer of the stop loss insurance coverage provided under this Contract.

e. Any licensing fees or other governmental or regulatory charges of any kind.

Each party to this Contract shall indemnify and hold harmless the other party and the other party's directors, officers, employees and agents from and defend against any and all claims, lawsuits, judgments, settlements and expenses, including reasonable attorney's fees, caused by the negligence or willful misconduct of the other party.

If Employer uses the services of a Claims Administrator to perform any functions for the Plan Document, the Claims Administrator performs as Employer's agent. MIC shall not be held liable for any act or omission of a Claims Administrator.

ARTICLE 9

DISPUTES

In the event that any dispute, claim or controversy of any kind or nature relating to this Contract arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. The party requesting the meeting shall provide the other, in advance of the meeting, with written notice of the claimed dispute. Upon receipt of the written notice, representatives for each party shall meet promptly to attempt to resolve the dispute. If a mutually agreeable resolution is not reached within thirty (30) days following receipt of the written notice, either party may pursue legal action in accordance with the terms of this Contract. The parties may

mutually agree to waive the informal dispute resolution process set forth herein. Any such waiver must be in writing and executed by both parties.

ARTICLE 10

SUBROGATION AND COORDINATION OF BENEFITS

Employer may be entitled to recover, directly or indirectly, from third parties for a claim Employer has paid. If Employer recovers from a third party, Employer shall not use the recovered amount to meet any deductible under this Contract. MIC shall not reimburse Employer for the recovered amount. If MIC has reimbursed Employer for all or part of a particular claim and Employer later recovers for that claim, directly or indirectly from a third party, Employer must repay MIC to the extent of MIC's reimbursement, regardless of when payment was made under this Contract or whether this Contract is still in force on the date of such recovery. Employer's repayment may be reduced by the reasonable and necessary expenses Employer has paid in recovering from the third party. Employer must notify MIC of any third party action or obligation affecting MIC's obligations under this Contract.

ARTICLE 11

REGULATORY COMPLIANCE

Employer shall comply, and ensure that the Plan complies with all applicable law and regulations. MIC will obtain and maintain any licenses or regulatory approvals necessary for it to perform its services under this Contract.

If by virtue of this Contract, (i) MIC, Plan or Employer, or (ii) any payments for claims for Health Services or fees to MIC, are subjected to any form of governmental or regulatory charges, including any premium taxes, insolvency fund fees, guarantee fund fees, licensing fees or any similar charges, such charges shall be the sole responsibility of the Employer or the Plan and the Employer shall hold harmless and indemnify MIC from the payment of any such charges.

If MIC's performance under this Contract is made materially more burdensome or expensive due to a change in federal, state or local laws or regulations during the term of this Contract, the parties shall negotiate an appropriate adjustment to the fee paid to MIC. If the parties cannot agree on an adjusted fee within 30 days after MIC sent written notice of the material change and its request to negotiate an adjusted fee to Employer, then MIC may terminate this Contract upon 30 days written notice to Employer.

In the event that any state or federal legislative or executive body enacts or promulgates legislation or regulation affecting the obligation of the parties under this Contract, the parties agree to amend this Contract in order to comply with any such legislation or regulation.

ARTICLE 12

GENERAL PROVISIONS

Section 12.1 Entire Contract. This Contract includes the entire understanding of the parties and may not be amended except in writing signed by both parties.

Section 12.2 Amendments to the Plan Document. No changes to the Plan Document shall be covered under this Contract unless such changes have first been accepted by MIC.

Section 12.3 Amendments to this Contract. This Contract may be amended only in writing signed by each of the parties.

Section 12.4 Independent Contractor Relationship. The relationship between the parties is solely one of independent contractors and nothing in this Contract shall be construed or deemed to create any other relationship between the parties, including one of employment, agency or joint venture, unless specifically set forth herein.

Section 12.5 Notices. All notices required under this Contract shall be given in writing signed by the party giving notice and delivered by hand, overnight delivery, or first-class mail to the other party at the address set forth below or such other address as has been given by proper notice.

Section 12.6 No Waiver of Rights. The failure of any party to insist upon the strict observation or performance of any provision of this Contract or to exercise any right or remedy shall not impair or waive any such right or remedy.

Section 12.7 Governing Law. This Contract will be governed by the law of the state of Minnesota. Any legal action arising out of or relating to this Contract shall be brought in state court in Hennepin County, Minnesota.

Section 12.8 Headings. The section headings contained in this Agreement are inserted for convenience only and shall not affect in any way the meaning or interpretation of this Agreement.

Section 12.9 No Third Party Beneficiaries. No person or entity other than MIC and Employer have any legal or equitable right, remedy or claim under this Contract. It is understood that the provisions of this Contract are for the sole benefit of Employer and MIC and no other person or entity shall be or be deemed a third party beneficiary to this Contract.

Section 12.10 ERISA. When the Plan Document provides benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. '1001 et seq. ("ERISA"), MIC is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Section 12.11 Clerical Error. Clerical error shall not change the rights or obligations of Employer or MIC and shall not operate to grant additional coverage to Covered Persons.

Section 12.12 Payment of Premium. Premium must be paid on or before the Premium Due Date. The premium rates are specified in the Stop Loss Schedule. MIC may change the premium rate for this Contract Period with 30 days advance written notice. Advance written notice of premium changes is not applicable in the case of a Plan Document change in accordance with Section 12.2 and in accordance with Sections 4.1 and 5.3.

Examples which could cause rate changes to occur include but are not limited to the following:

a. A Substantial Change;

b. Strike or work-stoppage; or

c. Elimination of another insurance carrier or plan offering.

Section 12.13 Grace Period. If any premium is not paid on or before the Premium Due Date and Employer has not given MIC written notice of termination of this Contract as stated below, Employer shall be given a grace period of 10 days for paying the premium. The grace period shall begin on the Premium Due Date. The premium must be received by MIC by the 10th day following the Premium Due Date.

Section 12.14 Renewal. This Contract shall automatically renew on each contract anniversary date upon timely payment of premiums at the rates set by MIC. MIC may refuse to renew this Contract by giving Employer 30 days advance written notice.

Section 12.15 Termination of this Contract. This Contract shall terminate on the earliest of the following dates:

a. The date of the expiration of its term, as set forth in the Stop Loss Schedule.

b. The last day of the last month for which premium has been paid, if the grace period ends and any premium remains unpaid.

c. The date specified by Employer after at least 30 days prior written notice of termination to MIC.

d. The date specified by MIC after at least 30 days prior written notice of termination to Employer.

e. The date the Plan Document ends.

f. The date the agreement between Employer and Claims Administrator terminates and MIC does not approve of the new Claims Administrator. Such approval shall not be unreasonably withheld by MIC.

g. The date of Employer's non-compliance with any or all of the provisions of this Contract.

h. The date Employer fails to make any payment to MIC when such payment is due under this Contract, but not before the expiration of the grace period.

i. The date specified by MIC in written notice of termination to Employer upon discovery of false, material information relevant to underwriting the risk.

j. The date written notice is given to Employer in the event Employer ceases to be actively engaged in business or if the Plan is terminated.

Section 12.16 Survival. The provisions of Article 7. Records and Reports, Article 8. Liability and Indemnification, and Article 9. Disputes, and Article 10. Subrogation and Coordination of Benefits, survive any termination of this Contract.

In the event that any governmental agency or court of law determines that the coverage provided under this Contract is primary or direct insurance, or makes any similar determination, or determines that any term or condition of this Contract must be changed, this Contract shall automatically terminate on the effective date of such determination.

MIC has, by its Vice President & General Manager, Client Retention & Growth, executed this Contract at its principal office in Minnetonka, Minnesota.

Medica Insurance Company
P.O. Box 9310
Minneapolis, MN 55440-9310

By:

Paul Crowley
Vice President & General Manager,
Client Retention & Growth

By:

James P. Jacobson
Senior Vice President and Assistant Secretary

McLeod County
830 11th Street East
Glencoe, MN 55336

By_____

Its_____

Dated_____

Sibley County
P.O. Box 256
400 Court Avenue
Gaylord, MN 55334

By_____

Its_____

Dated_____

McLeod County bids for 2016 Official Newspaper

Presented at January 5, 2016 Board meeting

	Hutchinson Leader	McLeod Publishing
Line length in Picas	10.25	10.6
Line per inch	9	9
Length of LCA in Points	90	102
Cost per column inch	$5.08	$3.00
2nd publications	$0.050	Official Newspaper

Board Workshop
March 1, 2016
Following Board Meeting

AGENDA

A. Discuss Market Study and meeting with Unions.

B. Discuss enabling Solid Waste staff to accept credit card payments for recycling at mobile sites.

CC: Commissioners
Department Heads