TRIPLE GOLD HEALTH CARE PLAN

For Employees of:

NETT LAKE ISD #707

(herein called the Plan Administrator or the Employer)

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Group Number: XXXXX-XX XXX
Identification Number: ON FILE

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ANNUAL NOTIFICATIONS

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services:

1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

Important Notice From the Plan Administrator About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Cross and Blue Shield of Minnesota (Blue Cross) and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Blue Cross has determined that the prescription drug coverage offered by your Plan is, on average for all members, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2)-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Blue Cross coverage will not be affected. You may keep your current Blue Cross coverage and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Blue Cross drug coverage, be aware that you and your dependents might not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Blue Cross and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Customer Service at the telephone number listed in the Customer Service section.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through Blue Cross changes. You may request a copy of this notice any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**, TTY users should call **1-877-486-2048**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Rights and Responsibilities

You have the right under this Plan to:

- be treated with respect, dignity and privacy;
- receive quality health care that is friendly and timely;
- have available and accessible medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care providers in decisions about your treatment;
- give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the Plan, the Claims Administrator, and its health care providers in accordance with existing law;
- receive information about the Plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the Plan, the Claims Administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the Claims Administrator and receive a prompt and fair review;
- initiate a legal proceeding when experiencing a problem with the Plan or its providers;
- Medicare enrollees have the right to voluntarily disenroll from the Plan. The Plan may not encourage or request you to disenroll except in circumstances specified in federal law; and
- Medicare enrollees have the right to a clear description of nursing home and home health care benefits covered by the Plan.

You have the responsibility under this Plan to:

- know your health plan benefits and requirements;
- provide, to the extent possible, information that the Plan, the Claims Administrator, and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered; and
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

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INTRODUCTION

This Summary Plan Description (SPD) contains a summary of the Nett Lake Isd #707 Triple Gold Health Care Plan for benefits effective 09-01-2012.

Coverage under this Plan for eligible employees and dependents will begin as defined in the Eligibility section.

All coverage for dependents and all references to dependents in this SPD are inapplicable for employee-only coverage.

This Plan, financed and administered by the Northeast Service Cooperative - Schools and Nett Lake Isd #707, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross), under contract with the Northeast Service Cooperative - Schools is the Claims Administrator and provides administrative services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity.

This Plan is not subject to ERISA.

The Plan provides benefits for covered services you receive from eligible health care providers. Primary Network Providers are providers that have entered into a specific network contract with the Claims Administrator to provide you quality health services. For most services the Primary Care Clinic (PCC) that you selected at enrollment is your Primary Network Provider. For some services you are able to obtain Primary Network coverage without a referral from your PCC. Please refer to How to Obtain Health Care Services for more information.

Extended Network Providers should be your second choice for care outside the Primary Network. Extended Network Providers have entered into a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan, but are not considered Primary Network Providers. However, you will still have less out-of-pocket expense and paperwork with Extended Network Providers than with Nonparticipating Providers.

You may also choose to see a Nonparticipating Provider. These providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan, and you may pay a greater portion of your health care expenses.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. It is also important that you read this entire SPD carefully. It explains the Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed in the Customer Service section.

CUSTOMER SERVICE

Questions?	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Our customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters. Monday through Thursday: 7:00 AM – 7:00 PM United States Central Time Friday: 9:00 AM – 6:00 PM United States Central Time *Hours are subject to change without prior notice.*
Customer Service Telephone Number	Claims Administrator: (651) 662-5517 or toll-free 1-888-878-0136
Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmn.com
BlueCard Telephone Number	Toll-free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield Plans nationwide.
BlueCard Website	www.bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield Plans nationwide.
Claims Administrator's Mailing Address	Claims review requests and written inquiries may be mailed to the address below: Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164 Prior authorization requests should be mailed to the following address: Blue Cross and Blue Shield of Minnesota Medical Review Department P.O. Box 64265 St. Paul, MN 55164
Pharmacy Telephone Number	Toll-free 1-800-509-0545 This number is used to locate a participating pharmacy.

A copy of the Claims Administrator's privacy procedures is available on the Claim's Administrator's website or by calling Customer Service at the telephone number listed above.

COVERAGE INFORMATION

Choosing A Health Care Provider

You must choose a Primary Care Clinic (PCC) at the time of enrollment. PCC's include family practice, multi-specialty providers and pediatric specialty providers. Eligible dependent children may select a participating pediatric specialty provider as their PCC.

Your PCC is a Primary Network Provider and will provide or arrange most necessary health care services. You may also use Extended Network or Nonparticipating Providers whenever you need care. However, there are significant benefit differences when you receive care outside the Primary Network, and you may be required to pay all or part of the resulting charges.

If you want to know more about the professional qualifications of a specific health care provider, call the provider or clinic directly.

Changing Your Primary Care Clinic (Primary Network Only)

A change in Primary Care Clinic locations may be made upon request. The effective date will be the first day of the month following the receipt date. To request a PPC change, call the customer service telephone number or write to the customer service address provided in the Customer Service section.

How To Obtain Health Care Services

Primary Network Providers

Services From Your Primary Care Clinic (PCC)

You may make an appointment with any physician in the PCC you have chosen. If you have a medical condition that requires hospitalization or the services of a specialist, the PCC will make arrangements for you to receive the necessary care. It is up to the PCC to determine when hospitalization or the services of a specialist are necessary. When you require hospitalization, the PCC will notify the Claims Administrator that the admission has been scheduled. When you need the services of a specialist, the PCC will notify the Claims Administrator. The Claims Administrator will send a form that identifies the specialist to whom you are being referred, the number of visits you may make, and the length of time in which those visits may be made. One (1) copy of the referral authorization form will be sent to your PCC, one (1) copy will be sent to the specialist, and one (1) copy will be sent to you.

Services Referred By Your Primary Care Clinic

Your PCC is responsible for providing or referring most necessary health care services. In general, your PCC will not make a referral for services that they are able to provide.

In some cases, your PCC may determine that you need care which your PCC cannot directly provide. When this care is referred in advance by your PCC, Primary Network benefits apply and prior authorization is not required. Referrals are not given to accommodate personal preference, family convenience, or other nonmedical reasons.

If for any reason you change your PCC selection, referral authorizations from the former PCC are invalid after the date of the change. You should contact the new PCC and explain why you are being referred to the hospital or the specialist. The new PCC may be able to provide the services directly, or may refer you to a different hospital or specialist.

If you choose to obtain care outside your PCC without a referral, benefits are paid according to the Extended Network or Nonparticipating Provider level of benefits, depending on the provider you choose except for certain services noted

below. Your PCC is not obligated to refer services which you choose to receive outside your PCC without your PCC's approval.

Services from an Urgent Care Clinic

Urgent care services are not medical emergency services, but require care sooner that the next available clinic appointment. If the situation is not a medical emergency, and you are using an Urgent Care facility not affiliated with your clinic, you must call your PCC before receiving care. Each PCC can provide information to you on your care 24 hours a day, seven days a week. When you call, you will be directed to the appropriate place of treatment for your situation. If you do not contact your PCC, reimbursement may be reduced or even denied depending on the terms of your Plan.

Services for a Medical Emergency

Be prepared for the possibility of an emergency by knowing your PCC's procedures for care after regular clinic hours before the need arises. Determine the telephone number to call, the hospital your PCC uses, and other information that will help you act quickly and correctly. Keep this information in an accessible location in case an emergency arises.

If the situation is life threatening, you should go to the nearest facility. Your PCC must be notified as soon as possible so that they can coordinate all subsequent care. If the situation is not life threatening, you must call your PCC before receiving care. Each PCC has someone on call 24 hours a day, seven days a week. When you call, you will be directed to the appropriate place of treatment for your situation. If you do not contact your PCC, the Plan may reduce or deny coverage for services that the Claims Administrator determines are not medical emergencies. When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.

If you are admitted for an emergency service to a hospital that your PCC does not use, the PCC may decide to transfer you to the PCC's designated hospital. In that case, the Plan will provide coverage for the ambulance used during the transfer.

Services From Obstetricians and Gynecologists (OB/GYN)

Female employees and/or covered female dependents may obtain the following services from your PCC or from Obstetrician/Gynecologist (OB/GYN) Network providers at the Primary Network level of benefits without a referral from their PCC:

1. annual preventive medical evaluations and any medically necessary follow-up visits;
2. maternity care; and
3. evaluation and necessary treatment for acute gynecologic conditions or emergencies.

Services From Chiropractors

You may obtain services from your PCC if they are eligible to provide chiropractic care. You may also obtain services from a Select Chiropractic Network Provider without obtaining a referral from your PCC. Please consult your provider directory for a listing of chiropractors in the Select Chiropractic Network.

If you choose to obtain care outside the PCC or Select Chiropractic Network, your benefits are paid according to the Extended Network or Nonparticipating Provider level of benefits, depending on the provider you choose.

Services From Mental Health and/or Substance Abuse Professionals

You may obtain services from your PCC if they are eligible to provide mental health and/or substance abuse services. You may also obtain services from a Behavioral Health Select Network Provider without a referral from your PCC.

Call the Customer Service telephone number provided in the Customer Service section prior to obtaining treatment and Customer Service will direct you to the appropriate Behavioral Health Select Network Provider.

Services For Routine Vision Exams

You may receive preventive vision exams and services (except for eye surgery procedures, other professional services not related to eye care services and consultation procedures), at the Primary Network level of benefits without a referral from your PCC when performed by a provider who has a network contract with the Claims Administrator.

Extended Network Providers

When you use an Extended Network Provider your benefits will be lower than when you obtain care through the Primary Network, and you may be required to pay deductibles, copays, and coinsurance that do not apply in the Primary Network. Extended Network Providers send your claims to the Claims Administrator, and the Claims Administrator sends payment to them for covered services you receive. Minnesota Extended Network Providers accept our payment based on the allowed amount. Some Extended Network Providers outside of Minnesota may not accept the Claims Administrator's payment based on the allowed amount. The Claims Administrator recommends that you contact the out-of-state provider and verify if they accept payment based on the allowed amount to determine if you will have additional financial liability. The Extended Network Provider Directory lists these providers, and may change as providers initiate or terminate their network contracts. For benefit information, refer to the Benefit Chart.

Nonparticipating Providers

When you use a Nonparticipating Provider you pay more of the bill. You pay deductibles, copays, and coinsurance, plus all charges that exceed the allowed amount the Plan pays to the PCC or most Extended Network Providers. In most cases, the Plan pays benefits to you directly, and you are responsible for paying the provider in full. For benefit information refer to the Benefit Chart.

Your Benefits

This SPD outlines the coverage under this Plan. Please be certain to check the Benefit Chart section to identify covered benefits. You must also refer to the General Exclusions section to determine services that are not covered. The Glossary of Common Terms section defines terms used in this SPD. All services must be medically necessary to be covered, and even though certain noncovered services may be medically necessary, there is no coverage for them. If you have questions, call Customer Service using the telephone number on the back of your ID card.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to Blue Cross, this section applies to you. If you are currently receiving care from a family practice or specialty physician who does not participate with the Claims Administrator, you may request to continue to receive care from this physician for a special medical need or condition, for a reasonable period of time before transferring to a participating physician as required under the terms of your coverage with this Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable 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 that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.

Transition to Participating Providers

At your request, the Claims Administrator will assist you in making the transition from a Nonparticipating to a Participating Provider. Please contact the Claims Administrator's customer service staff for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) accept the Claims Administrator's allowed amount; 2) adhere to all of the Claims Administrator's prior authorization requirements; and 3) provide the Claims Administrator with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with the Claims Administrator, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Participating Provider must occur on or prior to the date of such termination for you to continue to receive Primary Network benefits.

Provider Termination for Cause

If the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Participating Provider must occur immediately on or prior to the date of such termination for you to continue to receive Primary Network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your participating primary care clinic or physician and the Claims Administrator ends, rendering your clinic or provider nonparticipating with the Claims Administrator, and the termination was by Blue Cross and was not for cause, you may request to continue to receive care for a special medical need or condition, for a reasonable period of time before transferring to a Participating Provider as required under the terms of your coverage with this Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable 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 that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.

Transition to Participating Providers

At your request, the Claims Administrator will assist you in making the transition from a Nonparticipating to a Participating Provider. Please contact the Claims Administrator's customer service staff for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) accept the Claims Administrator's allowed amount; 2) adhere to all of the Claims Administrator's prior authorization requirements; and 3) provide the Claims Administrator with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with the Claims Administrator, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Participating Provider must occur on or prior to the date of such termination for you to continue to receive Primary Network benefits.

Provider Termination for Cause

If the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Participating Provider must occur on or prior to the date of such termination for you to continue to receive Primary Network benefits.

Payments Made in Error

Payments made in error or overpayments may be recovered by the Claims Administrator as provided by law. Payment made for a specific service or erroneous payment shall not make the Claims Administrator or the Plan Administrator liable for further payment for the same service.

Liability for Health Care Expenses

Charges That Are Your Responsibility

When you use Primary Network Providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay only the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

When you use Extended Network Providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All Extended Network Providers in Minnesota accept the Claims Administrator's payment based on the allowed amount. Most Extended Network Providers outside Minnesota also accept the Claims Administrator's payment based on the allowed amount. However, contact your Extended Network Provider outside Minnesota to verify if they accept the Claims Administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay only the following amounts:

1. charges that exceed the allowed amount when the out-of-state Extended Network Provider does not accept the Claims Administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

When you use Nonparticipating Providers for covered services, payment is still based on the allowed amount. However, because a Nonparticipating Provider has not entered into a network contract with the Claims Administrator, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. You are responsible for

payment of any billed charges that exceed the allowed amount. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered, including services that the Claims Administrator determines are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary.

Inter-Plan Programs

Out-of-Area Services

Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross' service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Blue Cross and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Blue Cross' service area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Nonparticipating Providers. Blue Cross' payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, Blue Cross will remain responsible for fulfilling Blue Cross' contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you access covered health care services outside Blue Cross' service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed covered charges for your covered services; or
- the negotiated price that the Host Blue makes available to Blue Cross.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

Nonparticipating Providers Outside Blue Cross' Service Area

1. Member Liability Calculation

   When covered health care services are provided outside of Blue Cross' service area by Nonparticipating Providers, the amount you pay for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. Where the Host Blue's pricing is greater than the Nonparticipating Provider's billed charge or if no pricing is provided by a Host Blue, we generally will pay based on the definition of "Allowed Amount" as set forth in the Glossary of Common Terms section of this SPD. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Blue Cross will make for the covered services as set forth in this paragraph.

2. Exceptions

   In certain situations, Blue Cross may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Blue Cross will pay for services rendered by Nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Blue Cross will make for the covered services as set forth in this paragraph.

General Provider Payment Methods

Participating Providers

Blue Cross and Blue Shield of Minnesota (Blue Cross), the Claims Administrator, contracts with a large majority of doctors, hospitals and clinics in Minnesota to be part of its network. Other Blue Cross and/or Blue Shield Plans contract with providers in their states as well. (Each Blue Cross and/or Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.) Each provider is an independent contractor and is not an agent or employee of the Claims Administrator, another Blue Cross and/or Blue Shield Plan, or the Blue Cross and Blue Shield Association. These health care providers are referred to as "Participating Providers." All Minnesota Participating Providers have agreed to accept as full payment (less deductibles, coinsurance and copays) an amount that the Claims Administrator has negotiated with its Participating Providers (the Allowed Amount). Most Participating Providers outside Minnesota have also agreed to accept as full payment (less deductibles, coinsurance and copayments) an amount that the Blue Cross and/or Blue Shield Plan has negotiated with its Participating Providers. However, some Participating Providers in a small number of states may not be required to accept the Allowed Amount as payment in full for your specific plan and will be subject to the Nonparticipating Provider payment calculation noted below. We recommend that you verify with your out-of-state Participating Provider if they accept the Allowed Amount as payment in full. The allowed amount may vary from one provider to another for the same service.

Several methods are used to pay Participating Providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their patients and further based on claims savings that the provider may generate in the course of rendering cost effective care to its member patients. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payments.

- **Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments**

  Fee-for-Service • Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.

  Discounted Fee-for-Service • Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.

  Discounted Fee-for-Service, Withhold and Bonus Payments • Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 - 20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per person per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

- **Institutional (i.e., hospital and other facility) Participating Provider Payments**

  Inpatient Care

  - **Payments for each Case (case rate)** • Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). The method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
  - **Payments for each Day (per diem)** • Providers are paid a fixed amount for each day the patient spends in the hospital or facility
  - **Percentage of Billed Charges** • Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.

  Outpatient Care

  - **Payments for each Category of Services** • Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
  - **Payments for each Visit** • Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
  - **Payments for each Patient** • Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost we determine by comparing market prices (for generic drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under Special Circumstances below), the allowed amount will be one of the following, to be determined by the Claims Administrator at its discretion: (1) based upon a Minnesota Nonparticipating Provider fee schedule posted at www.bluecrossmn.com; (2) a percentage not less than 100% of the Medicare Allowed Charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield Plan: or, (5) pricing based upon a nationwide provider reimbursement database. The Allowed Amount for a Nonparticipating Provider is usually less than the Allowed Amount for a Participating Provider for the same service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the Plan and **you are responsible for paying the Nonparticipating Provider. The only exception to this is stated in Claims Procedures, Claims Payment.** This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. See the allowed amount definition for a more complete description of how payments will be calculated for services provided by Nonparticipating Providers.

1. Example of payment for Nonparticipating Providers

The following table illustrates the different out-of-pocket costs you may incur using Nonparticipating versus Participating Providers for most services. The example presumes that the member deductible has been satisfied and that the Plan covers 80 percent of the allowed amount for Participating Providers and 60 percent of the allowed amount for Nonparticipating Providers. It also presumes that the allowed amount for a Nonparticipating Provider will be less than for a Participating Provider. The difference in the allowed amount between a Participating Provider and Nonparticipating Provider could be more or less than the 40 percent difference in the following example.

	Participating Provider	**Nonparticipating Provider**
Provider Charge:	$150	$150
Allowed Amount:	$100	$60
Claims Administrator Pays:	$80 (80 percent of the allowed amount)	$36 (60 percent of the allowed amount)
Coinsurance Member Owes:	$20 (20 percent of the allowed amount)	$24 (40 percent of the allowed amount)
Difference Up to Billed Charge Member Owes:	None (provider has agreed to write this off)	$90 ($150 minus $60)
Total Member Pays:	$20	$114*

*The Claims Administrator will in most cases pay the benefits for any covered health care services received from a Nonparticipating Provider directly to the member based on the allowed amounts and subject to the other applicable limitations in the Plan. An assignment of benefits from a member to a Nonparticipating Provider generally will not be recognized. This figure, therefore, represents the net cost to the member after being reimbursed by the Claims Administrator.

• Special Circumstances

When you receive care from certain nonparticipating professionals at a participating facility such as a hospital outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g. the difference between the allowed amount and the provider's billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. This reimbursement also applies when you receive care in a nonparticipating hospital as a result of a medical emergency.

Example of Special Circumstances

Your doctor admits you to the hospital for an elective procedure. Your hospital and surgeon are Participating Providers. You also receive anesthesiology services, but you are not able to select the anesthesiologist. The anesthesiologist is not a Participating Provider. When the claim for anesthesiology services is processed, the Claims Administrator may pay an additional amount because you needed care, but were not able to choose the provider who would render such services.

The above is a general summary of The Plan's provider payment methodologies only. provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular plan.

Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available at the Claim's Administrator's website at www.bluecrossmn.com.

Recommendations by Health Care Providers

Your provider may suggest that you receive treatment from a specific provider or receive a specific treatment. Even though your provider may recommend or provide written authorization for a referral or certain services, the provider may be a Nonparticipating Provider or the recommended services may be specifically excluded. When these services are referred or recommended, a written authorization from your provider does not override any specific network requirements; notification requirements; or, Plan benefits, limitations or exclusions.

Services that are Investigative or not Medically Necessary

Services or supplies that are investigative or not medically necessary are not covered. No payment of benefits for investigative or not medically necessary services will be allowed under this Plan including payments for services you have already received. The terms "investigative" and "medically necessary" are defined in the "Glossary of Common Terms" section.

Fraudulent Practices

Coverage for you or your dependents will be terminated if you or your dependent engage in fraud of any type including, but not limited to: submitting fraudulent misstatements about your medical history or eligibility status on the application for coverage; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the Plan to use your or your dependent’s coverage.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central Time and ends at 12:00 a.m. United States Central Time the following day.

Medical Policy Committee

The Claims Administrator’s Medical Policy Committee determines whether new or existing medical treatment should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee’s goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered.

NOTIFICATION REQUIREMENTS

The Claims Administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your Plan including preexisting condition limitations, exclusions, deductibles, copays and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification and/or emergency admission notification.

Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered.

Primary Network Providers and Extended Network Providers in Minnesota will obtain prior authorization for you.

You are required to obtain prior authorization when you use Extended Network Providers outside of Minnesota (BlueCard Traditional Network Providers) or Nonparticipating Providers. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you. **If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.** The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

For prior authorization of urgently needed care, please refer to the Expedited Review Determination process in the Appeal Process section.

The prior authorization list* is subject to change due to changes in the Claim Administrator's medical policy. The most current list is available on the Claim Administrator's website or by calling Customer Service.

- **Cosmetic versus medically necessary procedures including, but not limited to:**
  brow ptosis repair; excision of redundant skin (including panniculectomy); reduction mammoplasty; rhinoplasty; scar excision/revision; mastopexy
- **Coverage of routine care related to cancer clinical trials**
- **Dental and oral surgery including, but not limited to:**
  services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; orthognathic surgery
- **Drugs including, but not limited to:**
  growth hormones; intravenous immunoglobulin (IVIG); oral fentanyl; subcutaneous immunoglobulin; rituximab for off-label usage; NPlate; Promacta; Tysabri; Cinryze; intravitrel implants; insulin-like growth factors; chelation therapy; botulinum toxin injections for off-label usage
- **Durable Medical Equipment (DME), prosthetics and supplies including but not limited to:**
  prosthetics and supplies; unlisted DME codes over $1,000; functional neuromuscular electrical stimulation; manual and motorized wheelchairs and scooters; respiratory oscillatory devices; heavy duty and enclosed hospital beds; pressure reducing support surfaces (group 2 and 3); wound healing treatment; implantable hearing devices or prosthetics; continuous glucose monitors; amino acid-based elemental formula; bone growth stimulators; communication assist devices; microprocessor controlled prosthetics
- **Genetic testing including, but not limited to:**
  hereditary breast cancer and/or ovarian cancer
- **Home health care**
- **Home infusion care involving drugs for which we require prior authorization**
- **Humanitarian use devices** (define as devices that are intended to benefit patients by treating or diagnosing disease or condition that affects fewer than 4,000 individuals in the United States per year, classified under the FDA Humanitarian Device Exemption)
- **Imaging service including but not limited to:**
  Breast Magnetic Resonance Imaging (MRI); CT colonography (virtual colonoscopy)

- **Reproduction treatments**
- **Surgical procedures including, but not limited to:**
  bariatric surgery; hyperhidrosis surgery; sex reassignment surgery; spinal cord stimulators; subtalar arthroereisis for treatment of foot disorders surgical treatment of obstructive sleep apnea and upper airway resistance syndrome; vagus nerve stimulation (for all conditions); spinal fusion; pelvic floor stimulation
- **Transplants,** except kidney and cornea

***The Claims Administrator reserves the right to revise, update and/or add to this list at anytime without notice. The current list is available on the Claims Administrator's website or by calling Customer Service.**

The Claims Administrator prefers that all requests for prior authorization be submitted in writing. Please refer to the Customer Service section for the telephone number and appropriate mailing address for prior authorization requests.

Preadmission Notification

Preadmission notification is a process whereby the provider, or you, inform us that you will be admitted for inpatient hospitalization. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

Primary Network Providers and Extended Network Providers in Minnesota are required to provide preadmission notification to the Claims Administrator for you.

If you are going to receive nonemergency care from Extended Network Providers outside of Minnesota (BlueCard Traditional Network Providers) or Nonparticipating Providers, you are required to provide preadmission notification to the Claims Administrator. Some of these providers may provide preadmission notification for you. Verify with your providers if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Please refer to Prior Authorization in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

1. Hospital acute care admissions;
2. Residential behavioral health treatment facilities; and,
3. Mental health and substance abuse admissions.

To provide preadmission notification, call the Customer Service telephone number provided in the Customer Service section. They will direct your call.

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or services. Preadmission certification includes current/length-of-stay review for inpatient admissions. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

Primary Network Providers and Extended Network Providers in Minnesota are required to provide preadmission certification for you.

If you are going to receive nonemergency care from Extended Network Providers outside Minnesota (BlueCard Traditional Network Providers) or Nonparticipating Providers, you are required to provide preadmission certification to the Claims Administrator. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Please refer to Prior Authorization in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

1. Acute rehabilitation (ACR) admissions;
2. Long-term acute care (LTAC) admissions; and,
3. Skilled nursing facilities.

To provide preadmission certification, call the Customer Service telephone number in the Customer Service section. They will direct your call.

Emergency Admission Notification

In order to avoid liability for charges that are not considered medically necessary, you are required to provide emergency admission notification to the Claims Administrator as soon as reasonably possible after an admission for pregnancy, medical emergency, or injury that occurred within 48 hours of the admission.

Primary Network Providers and Extended Network Providers in Minnesota are required to provide emergency admission notification for you.

If you receive care from Extended Network Providers outside of Minnesota (BlueCard Traditional Network Providers) or Nonparticipating Providers, you are required to provide emergency admission notification to the Claims Administrator. Some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you. **If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

To provide emergency admission notification, call the Customer Service telephone number provided in the Customer Service section. They will direct your call.

CLAIMS PROCEDURES

Claims Filing

You are not responsible for submitting claims for services received from Primary Care and Extended Network Providers. These providers will submit claims directly to the Claims Administrator for you and payment will be made directly to them. If you receive services from or Nonparticipating Providers, you may have to submit the claims yourself. If the provider does not submit the claim for you, send the claim to the Claims Administrator at the address provided in the Customer Service section.

Claims should be filed in writing within 30 days after a covered service is provided. If this is not reasonably possible, the Plan will accept claims for up to 12 months after the date of service. Normally, failure to file a claim within the required time limits will result in denial of your claim. These time limits are waived if you cannot file the claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

The Claims Administrator will notify you of the resolution of the claim on an Explanation of Health Care Benefits (EHCB) form within 30 days of the date the Claims Administrator receives the claim. If, due to matters beyond its control, the Claims Administrator is unable to make a determination within 30 days, the Claims Administrator may take an additional 15 days to make a determination and will inform you in advance of the reasons for the extension. If you do not receive a written explanation within 30 days (or 45 days if there has been an extension) you may consider the claim denied, and you may request a review of the denial.

If benefits are denied in whole or in part, the reason for the denial will be listed on the bottom of the EHCB form. You have the right to know the specific reasons for the denial, the provision of the Plan on which the denial was based, and if there is any additional information the Claims Administrator needs to process the claim. You also have the right to an explanation of the claims review procedure and the steps you need to take if you wish to have your claim reviewed. If you have questions that the EHCB form does not answer, please contact the Claims Administrator at the address or telephone numbers provided in the Customer Service section.

Right of Examination

The Claims Administrator and the Plan Administrator each have the right to ask you to be examined by a provider during the review of any claim. The Plan pays for the exam whenever the exam is requested by either the Claims Administrator or the Plan Administrator. Failure to comply with this request may result in denial of your claim.

Release of Records

You agree to allow all health care providers to give the Claims Administrator needed information about the care they provide to you. The Claims Administrator may need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. The Claims Administrator keeps this information confidential, but the Claims Administrator may release it if you authorize release, or if state or federal law permits or requires release without your authorization. If a provider requires special authorization for release of records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Claims Payment

When you or your dependents use a Primary or Extended Network Provider for covered services, the Plan pays the provider. When you or your dependents use a Nonparticipating Provider the Plan pays you. You may not assign your benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for covered services for a dependent child. When the Plan pays the provider at the request of the custodial parent, the Plan has met its obligation under the contract. This

provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and certain out-of-state institutional and medical/surgical providers.

The Plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

APPEAL PROCESS

Introduction

The Claims Administrator has a process to resolve appeals. You can call or write the Claims Administrator with your appeal. The Claims Administrator will send an appeal form to you upon request. If you need assistance, the Claims Administrator will complete the written appeal form and mail it to you for your signature. The Claims Administrator will work to resolve your appeal as soon as possible using the appeal process outlined below.

If your appeal concerns a covered health care service or claim, including medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, you may request an external review of the final decision the Claims Administrator makes about your appeal after you have exhausted the Claims Administrator's appeal process.

In addition, you may file your appeal with the Minnesota Commissioner of Commerce at any time by calling 651-296-4026 or toll-free at 1-800-657-3602.

Definitions

Adverse Benefit Determination means a denial, reduction, termination, or failure to make payment in whole or in part for a benefit, including those related to eligibility, recession of coverage, utilization review, or investigative status.

Appeal means any grievance that is not the subject of litigation concerning any aspect of the provision of health services under your SPD. If the appeal is from an applicant, the appeal must relate to the application. If the appeal is from a former member, the appeal must relate to the provision of health services during the period of time the appellant was a member. *Any appeal that requires a medical determination in its resolution must have the medical determination aspect of the appeal processed under the utilization review process described below.*

Appellant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits an appeal.

Member means an individual who is covered by a health benefit plan.

Oral Appeals

If you call or appear in person to notify the Claims Administrator that you would like to file an appeal, the Claims Administrator will try to resolve your oral appeal within 10 calendar days. If the Claims Administrator's resolution of your oral appeal is wholly or partially adverse to you, the Claims Administrator will provide you an appeal from that will include all the necessary information to file your appeal in writing. If you need assistance, the Claims Administrator will complete the written appeal form and mail it to you for your signature.

Written Appeals

You may submit your appeal in writing, or you may request an appeal form that will include all the necessary information to file your appeal. The Claims Administrator will notify you that the Claims Administrator has received your written appeal.

The Claims Administrator will inform you of the Claims Administrator's decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If the Claims Administrator is unable to make a decision within 30 days due to circumstances outside the Claims Administrator's control, the Claims Administrator may take up to 14 additional days to make a decision. If the Claims Administrator takes more that 30 days to make a decision, the Claims Administrator will inform you of the reasons for the extension.

You are entitled to examine all pertinent documents and to submit issues and comments in writing. If your health plan is subject to ERISA and the Claims Administrator's appeal determination is wholly or partially adverse to you, you may file suit in federal district court or use the following appeal procedure.

Process for Appeals that do not Require a Medical Determination

If the Claims Administrator's decision regarding an appeal is partially or wholly adverse to you, you may file an appeal of the decision in writing and request either a hearing or a written reconsideration.

Hearing Notification

If you request a hearing, you or any person you choose may present testimony or other information. The Claims Administrator will provide you written notice of the Claims Administrator's decision and all key findings within 45 days after the Claims Administrator receives your written request for a hearing. If you request a written reconsideration, you may provide the Claims Administrator any additional information you believe is necessary. The Claims Administrator will provide you written notice of the Claims Administrator's decision and all key findings within 30 days after the Claims Administrator receives your request for a written reconsideration. If you request, the Claims Administrator will provide you a complete summary of the appeal decision.

Written Reconsideration

You may submit your reconsideration in writing, or you may request a form that will include all the necessary information to file your reconsideration.

The Claims Administrator will notify you that we have received your written appeal.

During the course of our review, the Claims Administrator will provide you with any new evidence that the Claims Administrator consider or rely upon, as well as any new rationale for a decision.

Within 30 days of receiving your reconsideration and all necessary information, the Claims Administrator will notify you in writing of the Claims Administrator's decision and the reasons for the decision. If we are unable to make a decision within 30 days due to circumstances outside our control, the Claims Administrator may take up to 14 additional days to make a decision. If the Claims Administrator take more than 30 days to make a decision, the Claims Administrator will inform you in advance of the reasons for the extension.

You may present testimony in the form of written correspondence, including explanations or other information from you, staff persons, administrators, providers, or other persons. You may also present testimony by telephone to a Claims Administrator Appeal Liaison.

External Review

If your appeal concerns a covered health care service or claim, or medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, and you believe the Claims Administrator's appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf, may submit the appeal to external review. External review of your appeal will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Commerce along with a filing fee. The Commissioner may waive the fee in cases of financial hardship.

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

The external review entity will notify you and the Claims Administrator that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and the Claims Administrator must provide the external review entity any information to be considered. Both you and the Claims Administrator will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, the Claims Administrator, and

the Commissioner within 40 days of receiving the request for external review. The external review entity's decision is binding on the Claims Administrator, but not binding on you.

Process for Appeals When Utilization Review is Necessary

When a medical determination is necessary to resolve your appeal, the Claims Administrator will process your appeal using these utilization review appeal procedures. Utilization review applies a well-defined process to determine whether health care services are medically necessary and eligible for coverage. Utilization review includes a process to appeal decisions not to cover a health care service.

Utilization review applies only when the service requested is otherwise covered under this health plan.

In order to conduct utilization review, the Claims Administrator will need specific information. If you or your attending health care professional do not release necessary information, approval of the requested service, procedure, or admission to a facility may be denied.

Definitions

Attending health care professional means a health care professional with primary responsibility for the care provided to a sick or injured person.

Concurrent review meant utilization review conducted during a patient's hospital stay or course of treatment.

Determination not to certify means that the service you or your provider has requested has been found to not be medically necessary, appropriate, or efficacious under the terms of this health plan.

Prior authorization means utilization review conducted prior to the delivery of a service, including an outpatient service.

Provider means a health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes pharmacies, medical supply companies, independent laboratories, and ambulances.

Utilization review means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the services or admission.

Determinations

Standard review determination

When a medical determination is required, the Claims Administrator's initial determination will be communicated to you and your provider within 10 business days of the request provided that all information reasonably necessary to make a determination on your request has been made available to the Claims Administrator. When the Claims Administrator authorizes services, the Claims Administrator notify the provider by telephone and in writing. When the Claims Administrator determines not to authorize the services, the Claims Administrator notify the attending health care professional and hospital by telephone, and notify the attending health care professional, hospital, and member in writing. When a determination is made not to authorize a service, notification by telephone will be made within one (1) working day. Notification will include notice of the right to appeal and how to submit an appeal.

Expedited review determination

The Claims Administrator will use an expedited review determination when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the Claims Administrator will notify the attending health care professional, hospital and member of the decision as expeditiously as the member's medical condition requires, but no later than 24 hours from the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize services, notification will include notice that you and your attending health care professional may submit an expedited appeal, and how to submit an expedited appeal.

Appeals

Standard appeal

You or your attending health care professional may appeal, in writing or by telephone, the Claims Administrator's decision to not authorize services. The decision will be made by a health care professional who did not make the initial decision. The Claims Administrator will notify you and your attending health care professional of the Claims Administrator's determination within 30 days of receipt of your appeal.

The request for appeal should include:

1. the member's name, identification number and group number;
2. the actual service for which coverage was denied;
3. a copy of the denial letter;
4. the reason why you or your attending health care professional believe coverage for the service should be provided;
5. any available medical information to support your reasons for reversing the denial; and
6. any other information you believe will be helpful to the decision maker.

Expedited appeal

When the Claims Administrator does not authorize services under the expedited appeal procedure described above, and the attending health care professional believes that an expedited appeal is warranted, you and your attending health care professional may request an expedited appeal. You and your attending health care professional may appeal the determination over the telephone. The Claims Administrator's appeal staff will include the consulting physician or health care provider if reasonably available. When an expedited appeal is completed, the Claims Administrator will notify you and your attending health care professional of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from the Claims Administrator's receipt of the expedited appeal request. If your health plan is subject to ERISA, and the Claims Administrator's appeal decision is wholly or partially adverse to you, you may file suit in federal district court, or use the external review procedure below.

External Review

If the standard or expedited appeal determination is to not authorize services, you or your attending health care professional may request external review as described above.

This appeal process is subject to change if required or permitted by changes in state or federal law governing appeal procedures.

BENEFIT CHART

This section lists covered services and the benefits the Plan pays. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of this SPD and must be medically necessary.

Benefit Features, Limitations, and Maximums

Benefit Features	Your Liability
Copays	
• Emergency room facility copay	$40 per visit
• Office visit copay	$20 per visit
• Retail Health Clinic copay	$0 per visit
• Urgent Care office visit copay	$20 per visit
Prescription Drugs	
• **Preferred Generic Drugs:**	
Retail Pharmacy	$15 copay
90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	$30 copay
• **Non-preferred Generic Drugs**	
Retail Pharmacy	$15 copay
90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	$30 copay
• **FlexRx Preferred Brand Name Drugs**	
Retail Pharmacy	$30 copay
90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	$60 copay
• **Non-preferred Brand Name Drugs**	
Retail Pharmacy	$45 copay
90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	$90 copay
Deductible	
(Deductible carryover applies. The amount applied toward your deductible under this Plan, during the last three (3) months of the calendar year, that is applied toward your deductible under this Plan for the next calendar year. This amount will not be applied toward the Out-of-Pocket Maximum for the next calendar year.)	
• **Extended Network Providers and Nonparticipating Providers**	$200 per person per calendar year $600 per family per calendar year

Benefit Features	Limitations and Maximums

Out-of-Pocket Maximums	
• **Primary Network Providers**	$1,000 per person per calendar year $2,000 per family per calendar year
• **Extended Network Providers and Nonparticipating Providers**	$2,500 per person per calendar year $5,000 per family per calendar year

The following items are applied toward the medical Out-of-Pocket Maximum:

- coinsurance
- deductibles
- medical copays

The following items are NOT applied toward the medical Out-of-Pocket Maximum:

- applicable prescription drug member cost-sharing
- deductible carryover

Lifetime Maximum

• **Reproduction Treatments**	
all services combined (medical and prescription drugs)	$10,000

Benefit Descriptions

Please refer to the following pages for a more detailed description of Plan benefits.

AMBULANCE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	80%	80%	80%

NOTES:

- **Please see the Notification Requirements section.**
- Eligible services you receive from Extended Network Providers and Nonparticipating Providers apply to the Primary Care Provider out-of-pocket maximum.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

NOT COVERED:

- transportation services that are not medically necessary for basic or advanced life support
- transportation services that are mainly for your convenience
- please refer to the General Exclusions section

BEHAVIORAL HEALTH MENTAL HEALTH CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Outpatient health care professional charges for services including: assessment and diagnostic services individual/group/family therapy (office/in-home mental health services) neuro-psychological examinations • Professional health care charges for services including: clinical based partial programs clinical based day treatment clinical based Intensive Outpatient Programs (IOP)	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges that exceed the allowed amount.
• Outpatient hospital/outpatient behavioral health treatment facility charges for services including: evaluation and diagnostic services individual/group therapy crisis evaluations observation beds family therapy	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient health care professional charges	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: hospital based partial programs hospital based day treatment hospital based Intensive Outpatient Programs (IOP) all eligible inpatient services emergency holds	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Outpatient health care professional lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Outpatient health care professional diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

BEHAVIORAL HEALTH MENTAL HEALTH CARE (continued)

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Outpatient hospital/facility lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Outpatient hospital/facility diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Inpatient health care professional lab and diagnostic imaging	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient hospital/facility lab and diagnostic imaging	80%	60%, plus you pay any charges billed to you that exceed the allowed amount.	60%, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **To receive the highest level of coverage you must use a Behavioral Health Select Network Provider, unless your PCC provides the service.To locate an appropriate Behavioral Health Select Network Provider call the Customer Service telephone number: (651) 662-5517 or toll-free 1-888-878-0136 prior to obtaining treatment.**
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary.
- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Coverage provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone consultations, except for eligible E-Visits.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- services for mental illness that are not listed in the most recent edition of the *International Classification of Diseases*
- services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; evaluations that are not performed for the purpose of diagnosing or treating mental health disorders including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, shelter care, and lodging programs
- halfway house services
- services for marriage/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars
- educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- therapeutic day care and therapeutic camp services
- hippotherapy (equine movement therapy)
- charges made by a health care professional for email and physician/patient telephone consultations, except for eligible E-Visits
- please refer to the General Exclusions section

BEHAVIORAL HEALTH SUBSTANCE ABUSE CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Outpatient health care professional charges for services including: assessment and diagnostic services family therapy opioid treatment	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges that exceed the allowed amount.
• Outpatient hospital/outpatient behavioral health treatment facility charges for services including: Intensive Outpatient Programs (IOP) and related aftercare services	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient health care professional charges	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient hospital/residential behavioral health treatment facility charges	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Outpatient health care professional lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Outpatient health care professional diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

• Outpatient hospital/facility lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Outpatient hospital/facility diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Inpatient health care professional lab and diagnostic imaging	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Inpatient hospital/facility lab and diagnostic imaging	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **To receive the highest level of coverage you must use a Behavioral Health Select Network Provider, unless your PCC provides the service. To locate an appropriate Behavioral Health Select Network Provider call the Customer Service telephone number: (651) 662-5517 or toll-free 1-888-878-0136 prior to obtaining treatment.**
- Court-ordered treatment for substance abuse care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified substance abuse assessor is deemed medically necessary.
- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator. Court-ordered treatment for substance abuse care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- For home health related services, please refer to Home Health Care.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone consultations, except for eligible E-Visits.
- For medical stabilization during detoxification services billed by a hospital/facility, please refer to Hospital Inpatient or Hospital Outpatient.

NOT COVERED:

NOT COVERED:

- services for substance abuse or addictions that are not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating substance abuse conditions including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, shelter care, and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition
- charges made by a health care professional for email and physician/patient telephone consultations, except for eligible E-Visits
- please refer to the General Exclusions section

CHIROPRACTIC CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Office visits from a doctor of chiropractic • Manipulations	100% after you pay the office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Lab	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Diagnostic imaging	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Therapies • Other chiropractic services	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**

NOTES:

- **Please see the Notification Requirements section.**
- **To receive the highest level of coverage, you must use a Select Chiropractic Network Provider, unless your PCC provides the service. Otherwise, services are covered at the Extended Network Provider level.**
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.
- An office visit copay will be applied to the office visit, evaluation, or manipulation, not to exceed one (1) copay per visit.

NOT COVERED:

- services you receive from Nonparticipating Providers
- services for or related to vocational rehabilitation defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), or educational therapy (defined as special education classes, tutoring, and other non medical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable

NOT COVERED:

improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy to treat the member's condition
- custodial care
- please refer to the General Exclusions section

DENTAL CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: dental implants removal of impacted teeth or tooth extractions related orthodontia related oral surgery bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: orthognathic surgery related orthodontia	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges that exceed the allowed amount.
• Oral surgery and anesthesia for: removal of impacted teeth removal of a tooth root without removal of the whole tooth • Root canal therapy	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services must be started within six (6) months of the injury.
- The Plan covers anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges, please refer to Hospital Inpatient or Hospital Outpatient.
- For medical services, please refer to Hospital Inpatient, Hospital Outpatient, Physician Services, etc.
- Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.
- Bone grafts for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.

NOTES:

- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.

NOT COVERED:

- all orthodontia, except as specified in the Benefit Chart
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
- dental implants, except as specified in the Benefit Chart
- replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as specified in the Benefit Chart
- accident-related dental services started more than six (6) months after the injury
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section

EMERGENCY ROOM

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Outpatient hospital/facility charges emergency room	100% after you pay the emergency room facility copay.	100% after you pay the emergency room facility copay.	100% after you pay the emergency room facility copay.
• Outpatient health care professional charges	100%	100%	100%
• Professional lab	100%	100%	100%
• Professional diagnostic imaging	100%	100%	100%

NOTES:

- **Please see the Notification Requirements section.**
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, please refer to Hospital Inpatient and Physician Services.
- For urgent care visits, please refer to Hospital Outpatient and Physician Services.
- The emergency room facility copay is waived if you are admitted within 24 hours.
- Eligible services you receive from Extended Network Providers and Nonparticipating Providers apply to the Primary Care Provider out-of-pocket maximum.

NOT COVERED:

- please refer to the General Exclusions section

HOME HEALTH CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare or Plan approved home health care agency including, but not limited to: intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse • medical technologist • licensed registered dietician • respiratory therapist physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees use of appliances that are owned or rented by the home health agency home health care following early maternity discharge palliative care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law
- please refer to the General Exclusions section

HOME INFUSION THERAPY

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Home infusion therapy services when ordered by a physician • Solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Durable medical equipment • Ancillary medical supplies • Nursing services to: train you or your caregiver; or monitor the home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network level.**

NOT COVERED:

- services you receive from Nonparticipating Providers
- home infusion services or supplies not specifically listed as covered services
- nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- services that do not involve direct patient contact, such as delivery charges and recordkeeping
- please refer to the General Exclusions section

HOSPICE CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Hospice care for a terminal condition provided by a Medicare-approved hospice provider or other preapproved hospice, including: inpatient respite care general inpatient care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Hospice care for a terminal condition provided by a Medicare-approved hospice provider or other preapproved hospice, including: routine home care continuous home care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**

NOTES:

- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network level when you use Extended Network Providers.**
- Benefits are restricted to patients with a terminal condition (i.e., life expectancy of six (6) months or less.) The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

- services you receive from a Nonparticipating Provider
- room and board expenses in a residential hospice facility
- please refer to the General Exclusions section

HOSPITAL INPATIENT

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Semiprivate room and board and general nursing care (private room is covered only when medically necessary) • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription drugs and supplies used during a covered hospital stay • Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Lab	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Diagnostic imaging	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- The Plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant or other kinds of transplants, please refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- The Plan covers anesthesia and inpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.

NOT COVERED:

- communication services provided on an outpatient basis or in the home
- travel expenses for a kidney donor

NOT COVERED:

- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law
- please refer to the General Exclusions section

HOSPITAL OUTPATIENT

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • All other outpatient hospital care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Urgent care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- The Plan covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive, debilitating illness, including illness which may limit the patient's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- please refer to the General Exclusions section

MATERNITY

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Health care professional services for: delivery in a hospital/facility postpartum care	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible for all other eligible services, plus you pay any charges that exceed the allowed amount.
• Health care professional office and outpatient lab services for: delivery in a hospital/facility postpartum care	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.	60% after you pay the deductible, plus you pay any charges that exceed the Allowed Amount.
• Health care professional office and outpatient diagnostic imaging services for: delivery in a hospital/facility postpartum care	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.	60% after you pay the deductible, plus you pay any charges that exceed the Allowed Amount.
• Inpatient hospital/facility services for: delivery in a hospital/facility postpartum care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Outpatient hospital/facility services for: delivery in a hospital/facility postpartum care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.	60% after you pay the deductible, plus you pay any charges that exceed the Allowed Amount.
• Outpatient hospital/facility lab services for: delivery in a hospital/facility postpartum care	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.	60% after you pay the deductible, plus you pay any charges that exceed the Allowed Amount.

MATERNITY (continued)

• Outpatient hospital/facility diagnostic imaging services for: delivery in a hospital/facility postpartum care	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.	60% after you pay the deductible, plus you pay any charges that exceed the Allowed Amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- Please refer to How to Obtain Health Care Services for information on how female employees and/or covered female dependents may obtain direct access for certain services provided by obstetricians and gynecologists.
- For prenatal care services, please refer to Preventive Care.
- Please refer to the Eligibility section to determine when the newborn's coverage will begin if the newborn is added to the Plan.
- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
  Inpatient hospital coverage for the **mother**, if covered under this Plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of the stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to Home Health Care.
  Inpatient hospital coverage for the **newborn**, if added to the Plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to Home Health Care.
- Under federal Law, the Plan may require that a provider obtain authorization from the Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.

NOT COVERED:

- health care professional charges for deliveries in the home
- services for or related to adoption fees
- services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- childbirth classes
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- please refer to the General Exclusions section

MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds • Medical supplies, including splints, nebulizers surgical stockings, casts, and dressings • Insulin pumps, glucometers, and related equipment and devices • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years. • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp hair prosthesis (wigs) provided hair loss is due to alopecia areata. Maximum of $350 per person per calendar year. Deductible does not apply. • Custom foot orthoses only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet • Diabetic supplies including: cotton balls alcohol swabs other diabetic supplies	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.	75% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**

NOTES:

- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For coverage of insulin and diabetic supplies, please refer to Prescription Drugs and Insulin.
- For hearing aid exam services, please refer to Physician Services.

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding or as provided in this Benefit Chart
- personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary
- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; hot tubs; whirlpools; and incontinence pads or pants
- modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- foot orthoses, except as specified in the Benefit Chart
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
- duplicate equipment, prosthetics, or supplies
- services for or related to hearing aids or devices, except as specified in the Benefit Chart
- please refer to the General Exclusions section

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Office visits from a physical therapist or occupational therapist	100% after you pay the office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Therapies from a physical therapist or occupational therapist	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	**NO COVERAGE.**
• Office visits from a speech or language pathologist	100% after you pay the office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Therapies from a speech or language pathologist	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Office visits from a physician	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC.**
- Office visits include a physical therapy evaluation or re-evaluation; occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.
- An office visit copay is applied to evaluations, re-evaluations, and assessments, not to exceed one (1) copay per visit.
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to Hospital Inpatient and Hospital Outpatient.

NOT COVERED:

- services primarily educational in nature, except as specified in the Benefit Chart
- services for or related to vocational rehabilitation defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider

NOT COVERED:

- physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc., and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable amount of time, unless they are medically necessary and are part of specialized maintenance therapy for the member's condition
- custodial care
- please refer to the General Exclusions section

PHYSICIAN SERVICES

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Office visits for illness	100% after you pay the office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Office visit for Urgent Care	100% after you pay the urgent care office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Urgent Care outpatient professional visit	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• E-Visit	100% after you pay the office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Office visit at a Retail Health Clinic	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Allergy serum	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Allergy testing	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Allergy injections	80%	60% after you pay the deductible, plus you pay any charges billed to you that	60% after you pay the deductible, plus you pay any charges that exceed the

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
		exceed the allowed amount.	allowed amount.
• Bariatric surgery to correct morbid obesity including: anesthesia assistant surgeon	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Inpatient lab and diagnostic imaging • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization • Assistant surgeon • Kidney and cornea transplants • Injectable drugs administered by a health care professional • Palliative care	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Office and outpatient lab	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.
• Office and outpatient diagnostic imaging	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**

NOTES:

- Please refer to How to Obtain Health Care Services for information on how female employees and/or covered female dependents may obtain direct access for certain services provided by obstetricians and gynecologists.
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- If the following services are covered under your Plan, you are entitled to receive care at the Primary Network level of benefits for the following services from providers who are not affiliated with the Claims Administrator:
  the voluntary planning of the conception and bearing of children;
  the diagnosis of infertility;
  the testing and treatment of a sexually transmitted disease; or
  the testing of AIDS or other HIV-related conditions.
- For kidney transplants done in conjunction with an eligible major transplant, please refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  potential donor testing;
  donor evaluation and work-up; and
  hospital and professional services related to organ procurement.
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the physician's time.
- E-Visit is an online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers hearing aid exams/fittings/adjustments for children age 18 and younger.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- separate charges for pre-operative and post-operative care for surgery
- internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit
- cosmetic surgery to repair a physical defect
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- physician dispensed self-administered prescription drugs for reproduction treatment
- please refer to the General Exclusions section

PRESCRIPTION DRUGS AND INSULIN

The Plan Covers:	Participating Pharmacy	Nonparticipating Pharmacy
• Prescription drugs insulin prescribed drug therapy, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets supplies prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated Specialty drugs (see below) smoking cessation drugs over-the-counter nicotine replacement products amino acid-based elemental formula prescription prenatal vitamins prescription pediatric multivitamins with fluoride	When you present your ID card or otherwise provide notice of coverage at the time of purchase you pay the applicable member cost-sharing. Please refer to Prescription Drugs in the Benefit Chart.	You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. You will be reimbursed only the discounted pricing that has been negotiated between the Claims Administrator and a Participating Pharmacy for that prescription drug less your applicable member cost-sharing. Please refer to Prescription Drugs in the Benefit Chart.
• Designated over-the-counter (OTC) drugs with a physician's prescription	When you present your ID card or otherwise provide notice of coverage at the time of purchase, we pay 100%.	**NO COVERAGE.**
• Designated Specialty drugs purchased through a Specialty pharmacy network supplier (see **NOTES)**	When you present your ID card or otherwise provide notice of coverage at the time of purchase, you pay the applicable member cost-sharing. Please refer to Prescription Drugs in the Benefit Chart.	**NO COVERAGE.**
• Benefits are provided for specific prescription oral contraceptives and diaphragms which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). • Coverage is provided for specific emergency prescription contraceptives. See **NOTES**.	100%	100% of the Allowed Amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. You will be reimbursed only the discounted pricing that has been negotiated between us and a Participating Pharmacy for that prescription drug.

NOTES:

NOTES:

- **Please see the Notification Requirements section.**
- **The FlexRx Preferred drug list applies to your Plan. For a list of drugs on your specified Preferred drug list, contact Customer Service or visit the Claims Administrator's website.**
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.
- Specialty drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated Specialty prescription drugs and suppliers is available at the Claims Administrator's website or contact Customer Service. Specialty drugs are not available through 90dayRx.
- You have the option to obtain up to a 90-day authorized supply of ongoing, long-term prescription medications through a participating 90dayRx retail pharmacy or mail service pharmacy for your ongoing, long-term refills. You may visit the Claims Administrator's website or contact Customer Service to locate a retail pharmacy participating in the 90dayRx network or Mail Service Pharmacy.
- For more information regarding contraceptive coverage, please visit the Claims Administrator's website or contact Customer Service.
- Prescription drugs and diabetic supplies are covered in a 31-day supply from a retail pharmacy, or up to a 90-day supply from 90dayRx. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- Designated over-the-counter (OTC) drugs are generally covered up to a 31-day supply as an alternative for similar prescription medications, subject to package limitations, at a retail participating pharmacy. OTC drugs are not available through 90dayRx.
- Self-administered injectable and oral prescription drugs for or related to reproduction treatments must be obtained through a Specialty pharmacy network supplier and are subject to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
- The Plan will cover prescription smoking cessation products and over-the-counter (OTC) nicotine replacement products with a prescription subject to your applicable member cost sharing. Participant's in the Stop-Smoking Support may use documented enrollment in place of a prescription for the OTC nicotine replacement products. Some quantity limitations may apply.
- The Plan will cover off label drugs used for cancer treatment as specified by law.
- When identical chemical entities including Over-the-Counter (OTC) drugs and similar prescription alternatives are from different manufacturers or distributors, the Claims Administrator's Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
- Antipsychotic drugs and Preferred drugs prescribed to treat emotional disturbance or mental illness will be covered on the same basis (applicable level) as all other eligible prescription drugs, unless the drug was removed from eligibility for safety reasons. Please refer to Prescription Drugs in the "Benefit Chart."
- To locate a participating pharmacy in your area, call the pharmacy information telephone number provided in the Customer Service section.
- For drugs dispensed and used during an admission, please refer to Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, please refer to Medical Equipment, Prosthetics and Supplies.
- A compound drug is a prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution is added to the active ingredient.
- When you pay for the claim in full at the pharmacy or use an Out-of-Network Pharmacy you are required to submit the drug receipt(s) with the claim form for reimbursement.

NOTES:

- The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.

NOT COVERED:

- drugs removed from the Preferred drug list for safety reasons may not be covered
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and except as specified in the Benefit Chart
- over-the-counter smoking cessation drugs without a prescription or documented enrollment in Stop-Smoking Support
- charges for giving injections that can be self-administered
- over-the-counter drugs, except as provided in this Benefit Chart
- investigative or non-FDA approved drugs, except as required by law
- vitamin or dietary supplements, except as specified in the Benefit Chart
- Specialty drugs not purchased through a Specialty pharmacy network supplier
- selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects
- please refer to the General Exclusions section

PREVENTIVE CARE

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) for:			
Adults including, but not limited to: • cancer screenings required by law • age and gender appropriate periodic health examinations and screenings • gynecological screenings • vision screening (glaucoma, acuity, refraction) • hearing screening • laboratory screening and testing • diagnostic imaging screenings • standard immunizations Infants and children including, but not limited to: • infant and child screenings • developmental assessments • laboratory screening and testing • diagnostic imaging screenings • standard immunizations Prenatal care	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- Preventive care services comply with state and federal statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit the Claims Administrator's website or contact Customer Service.
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating level.**
- Please refer to How to Obtain Health Care Services for information on how female enrollees and female dependents may obtain direct access for certain services provided by obstetricians and gynecologists.
- You are entitled to receive care at the Primary Network level for the following services: screening for sexually transmitted disease or HIV.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP, or HRSA recommendations may be covered under other Plan benefits. Please refer to Hospital Outpatient, Hospital Inpatient and Physician Services for appropriate benefit levels.
- Benefits are provided for the *purchase* of one (1) manual breast pump within six (6) months of a covered member's newborn's birth.
- Benefits are provided for surgical implants for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage, please visit www.bluecrossmn.com (“Member Sign In” then “Plan Details”/”Preventive care benefit information”/”learn more”) or contact Customer Service.
- Benefits are provided for certain prescription contraceptive drugs and supplies for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health

NOTES:

Resources and Services Administration (HRSA). Please refer to “Prescription Drugs and Insulin” for outpatient drug coverage.
- Services for the removal of contraceptive drugs and devices, or complications related to contraceptive drugs and devices may be covered under other Plan benefits. Please refer to "Hospital Inpatient," "Hospital Outpatient," "Physician Services," etc.

NOT COVERED:

- services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining/maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request
- educational classes or programs, except educational classes or programs required by law
- services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
- treatment, services or supplies which are investigative or not medically necessary
- please refer to the General Exclusions section

RECONSTRUCTIVE SURGERY

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician • Treatment of cleft lip and palate when the services are scheduled or initiated prior to the member turning age 19 including dental implants • Elimination or maximum feasible treatment of port wine stains	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- Under the Federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures, or a dental prosthesis.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts
- dental implants and any associated services and/or charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section

REPRODUCTION TREATMENTS

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Professional services for: Artificial Insemination (AI) and Intrauterine Insemination (IUI) procedures Non-investigative Assisted Reproductive Technologies (ART) Drugs administered by a health care professional for eligible reproduction treatments	100% after you pay the office visit copay for the office visit charge; 80% for all other eligible services to the lifetime maximum limit of $10,000 per person for reproduction treatments for all networks combined.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount for all other eligible services to the lifetime maximum limit of $10,000 per person for reproduction treatments all charges and networks combined.	60% after you pay the deductible for the office visit charge; 60% after you pay the deductible, plus you pay any charges that exceed the allowed amount for all other eligible services to the lifetime maximum limit of $10,000 per person for all medical services for reproduction treatments for all charges and networks combined.
• Outpatient hospital/facility services for: AI and IUI procedures Non-investigative ART Drugs administered by a health care professional for eligible reproduction treatments	80% to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for all for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for all for reproduction treatments for all charges and networks combined.
• Professional lab services associated with reproduction treatments	100% to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.
• Hospital/facility lab services associated with reproduction treatments	100% to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount to the	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount to the lifetime

REPRODUCTION TREATMENTS (continued)

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
	networks combined.	lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.
• Professional diagnostic imaging services for reproduction treatments	100% to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.
• Hospital/facility diagnostic imaging services for reproduction treatments	100% to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount to the lifetime maximum limit of $10,000 per person for reproduction treatments for all charges and networks combined.
• Self-administered injectable and oral prescription drugs	For the level of coverage refer to "Prescription Drugs and Insulin."	For the level of coverage refer to "Prescription Drugs and Insulin."	For the level of coverage refer to "Prescription Drugs and Insulin."

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- Please refer to the Glossary of Common Terms section for definitions of AI, IUI, and ART.
- Benefits are subject to the lifetime maximum of $10,000 per person for all reproduction treatments for all charges and networks combined, including self-administered injectable and oral outpatient prescription drugs.
- For services related to infertility testing, please refer to Physician Services.

NOT COVERED:

- services for or related to reproduction treatments when the number of embryos transferred exceeds the current guidelines developed by the Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine
- services for or related to adoption fees and childbirth classes
- services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- services for or related to reversal of sterilization
- donor ova or sperm
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- physician dispensed self-administered prescription drugs for reproduction treatment
- please refer to the General Exclusions section

SKILLED NURSING FACILITIES

The Plan Covers:	Primary Network Providers	Extended Network Providers	Nonparticipating Providers
• Skilled care ordered by a physician • Semiprivate room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.	60% after you pay the deductible, plus you pay any charges that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- **Eligible services are covered at the Primary Network level if your PCC provides or refers the services, or you have contacted your PCC for a referral prior to services being provided and the referral is later approved by your PCC. Otherwise, services are covered at the Extended Network or Nonparticipating Provider level.**
- Skilled care ordered by a physician includes skilled care ordered by an optometrist, chiropractor, or advanced practice nurse when ordered within the scope of their licensure.
- For take home prescription drugs, please refer to Prescription Drugs and Insulin.

NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section

TRANSPLANT COVERAGE

The Plan Covers:	Blue Distinction Centers for Transplant (BDCT) Providers	Extended Network Providers	Nonparticipating Transplant Providers
• The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart-lung • Kidney - pancreas transplant performed simultaneously (SPK) • Liver - deceased donor and living donor • Lung - single or double • Pancreas transplant - deceased donor and living donor segmental Pancreas transplant alone (PTA) Simultaneous pancreas - kidney transplant (SPK) Pancreas transplant after kidney transplant (PAK) • Small-bowel and small-bowel/liver	100% of the Transplant Payment Allowance for the transplant admission. If you live more than 50 miles from a BDCT Provider, there may be travel benefits available for expenses directly related to a preauthorized transplant. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.	60% of the Transplant Payment Allowance after you pay the deductible for the transplant admission, plus you pay any charges billed to you that exceed the allowed amount. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.	**NO COVERAGE.**

NOTES:

- Kidney transplants when not done in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to Hospital Inpatient and Physician Services.
- **Prior authorization is required for human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P.O. Box 64179, St. Paul, Minnesota 55164 or faxed to 651-662-1624.**

NOT COVERED:

- travel benefits when you are using a Non-BDCT Provider
- services you receive from Nonparticipating Providers
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs and aftercare for or related to human organ transplants not specifically listed above as covered
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow transplant and peripheral stem cell support procedures that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this SPD
- transplantation of animal organs and/or tissue

NOT COVERED:

- please refer to the General Exclusions section

DEFINITIONS:

- *BDCT Provider* means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.
- *Participating Transplant Provider* means a hospital or other institution that has a contract with Blue Cross and Blue Shield of Minnesota or with their local Blue Cross and/or Blue Shield Plan to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures.
- *Transplant Payment Allowance* means the amount the Plan pays for covered services to a BDCT Provider or a Participating Transplant Provider for services related to human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures in the agreement with that provider.

*An association of independent Blue Cross and Blue Shield Plans.

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatment, services, or supplies which are not medically necessary.

2. Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by the Claims Administrator in advance of treatment.

3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.

4. Services that are provided without charge, including services of the clergy.

5. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.

6. Services for or related to therapeutic acupuncture, except for the treatment of chronic (defined as duration of at least six (6) months), or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.

7. Treatment of preexisting conditions incurred during the preexisting condition limitation period.

8. Services that are provided for the treatment of an employment-related injury for which you are entitled to make a worker's compensation claim, unless the worker's compensation carrier has disputed the claim.

9. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owners insurance, liability insurance ,etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement or such a policy.

10. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).

11. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.

12. Services for or related to treatment of illness or injury which occurs while on military duty that are recognized by the Veterans Administration as services related to service-connected injuries.

13. Services for dependents if you have employee-only coverage.

14. Services that are prohibited by law or regulation.

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

16. Charges for furnishing medical records or reports and associated delivery charges.

17. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the Benefit Chart.

18. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.

19. Services for or related to mental illness not listed in the most recent edition of the *International Classification of Diseases*.

20. Services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.

21. Services or confinements ordered by a court or law enforcement officer that are not medically necessary, except as specified under Minnesota law.

22. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offences; competency evaluations; adoption home status; parental competency; and domestic violence programs.

23. Services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services, and skills training.

24. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

25. Services for or related to marriage/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder.

26. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities except when medically necessary and provided by an eligible health care provider; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

27. Charges made by a health care professional for televideo conferencing services, email, and physician/patient telephone consultations, except for eligible E-Visits and as specified in the Benefit Chart.

28. Services for or related to substance abuse or addictions that are not listed in the most recent edition of the *International Classification of Diseases.*

29. Services for or related to substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition.

30. Services for or related to therapeutic massage.

31. Dentures, regardless of the cause or condition, and any associated services and/or charges, including bone grafts.

32. Dental implants, and associated services and/or charges, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19.

33. Services for or related to the replacement of a damaged dental bridge from an accident-related injury.

34. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.

35. Room and board expenses in a residential hospice facility.

36. Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by the Claims Administrator as medically necessary.

37. Admission for diagnostic tests that can be performed on an outpatient basis.

38. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law.

39. Personal comfort items, such as telephone, television, etc.

40. Communication services provided on an outpatient basis or in the home.

41. Services for or related to sex transformation/gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling, unless medically necessary as determined by the Claims Administrator prior to receipt of services.

42. Services for or related to reversal of sterilization.

43. Services for or related to adoption fees and childbirth classes.

44. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.

45. Donor ova or sperm.

46. Services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart.

47. Services and prescription drugs for or related to gender selection services.

48. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart.

49. Services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants.

50. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.

51. Blood pressure monitoring devices.

52. Foot orthoses, except as specified in the Benefit Chart.

53. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.

54. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.

55. Services for or related to hearing aids or devices, except as specified in the Benefit Chart.

56. Services primarily educational in nature, except as specified in the Benefit Chart.

57. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.

58. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.

59. Services and fees for or related to health clubs and spas.

60. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the member's condition.

61. Custodial care.

62. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc., and all related material and products for these programs.
63. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.
64. Services for or related to the repair of scars and blemishes on skin surfaces, except as specified in the Benefit Chart.
65. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
66. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart.
67. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.
68. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment: services for or related to homeopathy, or chelation therapy that the Claims Administrator determines is not medically necessary.
69. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
70. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.
71. Autopsies.
72. Charges for failure to keep scheduled visits.
73. Charges for giving injections that can be self-administered.
74. Internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
75. Services for or related to smoking cessation program fees and/or supplies.
76. Charges for over-the-counter drugs, except as specified in the Benefit Chart.
77. Vitamin or dietary supplements, except as specified in the Benefit Chart.
78. Investigative or non-FDA approved drugs, except as required by law.
79. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
80. Over-the-counter smoking cessation drugs without a prescription or documented enrollment in Stop-Smoking Support.
81. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

82. Services for or related to reproduction treatments when the number of embryos transferred exceeds the current guidelines developed by the Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine.

83. Charges for to physician dispensed self-administered prescription drugs for reproduction treatments.

84. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.

85. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.

86. Services for or related to fetal tissue transplantation.

ELIGIBILITY

Eligible Employees

All full-time employees working a minimum of 20 hours per week are eligible.

Retirees must contact the Plan Administrator for eligibility information.

The waiting period is 30 days.

This Plan covers only those employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Dependents

NOTE: A spouse who is covered as an employee under the employer is not an eligible dependent. A child who is covered as an employee under the employer or as an employee of any employer is not an eligible dependent. If both parents are covered as employees under the Plan, children may be covered as dependents of either parents but not both.

Spouse

Married spouse.

Dependent Children

1. Natural-born dependent children to age 26.
2. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
3. Stepchildren to age 26.
4. Dependent children for whom you or your spouse have been appointed legal guardian to age 26.
5. Grandchildren to age 26 for whom you provide the majority of financial support and who live with you or your spouse continuously from birth.
6. Otherwise eligible children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in Minnesota statute 518.171. The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

Disabled Dependents

1. Unmarried disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

    a. primarily dependent upon you;

    b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness, or mental disorders;

    c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and

    d. must have become disabled prior to reaching limiting age.

2. Disabled Dependents if both of the following apply:

   a. incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and

   b. chiefly dependent upon you for support and maintenance.

Preexisting Condition Limitation for Employees and Covered Dependents - Age 19 and Older

A preexisting condition limitation applies to employees and covered dependents - age 19 and older. A preexisting condition is defined as a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date.

Newly Eligible Applicants – For such a condition, benefits for you and your covered dependents will be payable only after a period of 12 consecutive months beginning from the enrollment date. This period will be reduced by any prior continuous creditable coverage, provided no gap in coverage greater that 63 days has occurred. At your request and with appropriate authorization the Claims Administrator will assist you in obtaining a certificate of creditable coverage from your prior plan.

With timely application, this limitation does not apply to a newborn infant, or a child placed with you for adoption. Preexisting condition does not include genetic information alone in the absence of a diagnosis for a condition related to the genetic information, or an existing pregnancy.

Late Entrants – For such a condition, benefits for you and your covered dependents will be payable only after a period of 18 months. This period will be reduced by any prior continuous creditable coverage, provided no gap in coverage greater that 63 days has occurred. At your request and with appropriate authorization the Claims Administrator will assist you in obtaining a certificate of creditable coverage from your prior plan.

Preexisting condition does not include genetic information alone in the absence of a diagnosis for a condition related to the genetic information, or an existing pregnancy.

Effective Date of Coverage

Coverage for you or your eligible dependents who were eligible on the effective date of the Plan will take effect on that date.

Adding New Employees

1. If the Plan Administrator receives your application within 30 days after you become eligible, coverage for you and your eligible dependents starts upon completion of the probationary period.

2. If the Plan Administrator receives your application more than 30 days after you become eligible, you and your eligible dependents will be considered a late entrant unless you meet the requirements of the special enrollment period. Please see Coverage Effective Date for Late Entrants in this section to determine when coverage will begin.

Adding New Dependents

This section outlines the time period for application and the date coverage starts.

Adding spouse and/or stepchildren

1. If the Plan Administrator receives the application within 30 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

2. If the Plan Administrator receives the application more than 30 days after the date of marriage, your spouse and/or stepchildren will be considered late entrants unless your spouse and/or stepchildren meet the requirements of the special enrollment period. Please see Coverage Effective Date for Late Entrants in this section to determine when coverage will begin.

Adding newborns and children placed for adoption

The Plan Administrator requests that you submit written application to add your newborn child or newborn grandchild within 90 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Administrator requests that you submit written application to add your adopted child within 90 days of the date of placement. Coverage for your adopted child starts on the date of placement.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Administrator receives the application. A disabled dependent will not be denied coverage and will not be subject to any preexisting condition limitation period.

Special Enrollment Periods

Special enrollment periods are periods when eligible employees or dependents may enroll in the Plan under certain circumstances **after they were first eligible for coverage**. The eligible circumstances are: 1) a loss of other group health plan coverage; 2) loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) coverage; 3) eligibility for premium assistance under Medicaid or CHIP; or 4) acquiring a new dependent. The request for enrollment must be within 30 days (unless otherwise noted) of the eligible circumstance.

Newborns, newborn grandchildren, and children placed for adoption are eligible as of the date of birth, adoption or placement for adoption. See Eligible Dependents in the Eligibility section.

1. Loss of Group Health Plan Coverage

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon a loss of other health plan coverage if all of the following conditions are met:

   a. the employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;
   b. the employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;
   c. the employee's or dependent's coverage is terminated because his/her COBRA continuation has been exhausted (not due to failure to pay premium or for cause), he/she is no longer eligible for the plan due to divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area, or the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
   d. the employee or dependent requests enrollment not later than 30 days after the termination of coverage or employer contribution, or the meeting or exceeding of the lifetime limit on benefits.

   Coverage for employees or dependents (other than newborns, newborn grandchildren and children placed for adoption - see Eligibility section) who are eligible to enroll in the Plan under the Special Enrollment Periods provision will be effective the day after the termination of prior coverage or the date of the claim denial due to meeting or exceeding the lifetime limit on all benefits.

2. Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

   a. the employees or dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the group member or dependent;

b. the employees must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and

c. the employees or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

3. Eligibility for Premium Assistance

   Employees or dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) if all the following conditions are met:

   a. the employer must submit any required documentation indicating that the group member and/or dependents are eligible for premium assistance through Medicaid or CHIP; and
   b. the employee or dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

4. Acquiring a New Dependent

   Eligible employees who are either enrolled or not enrolled in the health plan may enroll themselves and eligible dependents in the health plan as special enrollees when the eligible employee experiences a marriage, birth, adoption or placement for adoption. These events provide the eligible employee, spouse or child(ren) the opportunity to apply for coverage under the Plan during Special Enrollment Periods.

   Coverage for employees or dependents (other than newborns, newborn grandchildren and children placed for adoption – see Eligibility section) who are eligible to enroll in the Plan under the Special Enrollment Periods provision will be effective on the date of marriage, birth, adoption or placement for adoption.

Coverage Effective Date for Late Entrants

Late entrants - age 19 and older are subject to a preexisting condition limitation period described in the Preexisting Condition Limitations section. Credit will be given for prior continuous, qualifying creditable coverage, provided no gap in coverage greater that 63 days has occurred. Coverage for late entrants starts on the first of the month following the day the late application is received.

TERMINATION OF COVERAGE

Termination Events

When the Plan Administrator terminates coverage for all employees and dependents in your Plan, the Plan will give all employees and dependents a 30-day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months. The Plan will not give this notification in the event of voluntary cancellation or nonrenewal.

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Plan terminates.

2. For you and your dependents, last day of the month during which:
   a. required premiums for coverage were paid, if payment is not received when due. Your payment of premiums to the employer does not guarantee coverage unless the Claims Administrator receives full payment when due. If the Claims Administrator terminates coverage for all employees in the Plan for nonpayment of the premiums, the Claims Administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.

   b. you are no longer eligible.

   c. you enter military services for duty lasting more than 31 days.

   d. you request that coverage be terminated.

3. For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month when the employee and spouse divorce or legally separate.

4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month which:
   a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.

   b. the dependent child reaches the dependent child age limit.

   c. the dependent child becomes eligible for coverage under any employer-sponsored health plan other than a group health plan of a parent. Contact the Plan Administrator to determine if applicable to your Plan.

   d. the disabled dependent is no longer eligible.

   e. the dependent grandchild is no longer eligible.

Retroactive Termination

If the Plan Administrator erroneously enrolled the employee or dependent in the Plan and subsequently requests that coverage be terminated retroactive to the effective date of coverage, coverage will remain in force to a current paid-to-date unless the Plan Administrator obtains and forwards to the Claims Administrator the employee’s or dependent’s written consent authorizing retroactive termination of coverage. If written consent is not obtained and forwarded to the Claims Administrator with the cancellation request, the Plan Administrator must pay the required charges for the employee’s or dependent’s coverage in full to current paid-to-date.

Certification of Coverage

When you or your covered dependents terminate coverage under the Plan, a certification of coverage form will be issued to you specifying your coverage dates under the health plan and any waiting periods you were required to

satisfy. The certification of coverage form will contain all the necessary information another health plan will need to determine if you have prior continuous coverage that should be credited toward any preexisting condition limitation period. Health plans will require that you submit a copy of this form when you apply for coverage.

The certification of coverage form will be issued to you if you request it before losing coverage or when you terminate coverage with the Plan and, if applicable, at the expiration of any continuation period. The Claims Administrator will also issue the certification of coverage form if you request a copy at any time within the 24 months after your coverage terminates. To request a Certification of Coverage form, please contact the Claims Administrator at the address or telephone number listed in the Customer Service section or refer to your Identification (ID) Card.

Extension of Benefits

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the Claims Administrator, the Plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date Plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the administrative service agreement with the Claims Administrator has been terminated and your employer maintains continuous group coverage with a new claims administrator or insurer.

Continuation and Conversion

You or your covered dependents may continue this coverage if coverage ends due to one of the qualifying events listed below. You and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

Qualifying Events

If you are the ***employee*** and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment).
- Total disability - Total disability means the ***employee's*** inability to engage in or perform the duties of the ***employee's*** regular occupation or employment within the first two (2) years of disability. After the first two (2) years, it means the ***employee's*** inability to perform any occupation for which the ***employee*** is educated or trained.

If you are the ***spouse/ex-spouse*** of a covered ***employee***, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the ***employee***.
- A termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***employee***. (This includes if the ***employee*** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the Plan Administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.
- The ***employee*** becomes enrolled in Medicare.
- The ***employee*** becomes totally disabled (as defined above).

A ***dependent child*** of a covered ***employee*** has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the **employee**.

- The termination of the ***employee's*** employment (as described above) or reduction in the ***employee's*** hours of employment with the employer.
- Parents' divorce or legally separate.
- The ***employee*** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under the Plan.
- The total disability of the ***employee*** (as defined above).

Your Notice Obligations

You and your dependents must notify the employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legally separate;
- A dependent child no longer meets the Plan's eligibility requirements.

If you or your dependents do not provide this required notice, any dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependents do not provide this required notice you or your dependents must reimburse any claims mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your dependents will be required to reimburse the Plan for any claims paid.

Note: Disability Extensions also require specific notice. See below for these notification requirements.

When you notify the employer of a divorce or legal separation or a loss of dependent status, the employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the employer of a qualifying event or disability determination and the employer determines that there is no extension available, the employer will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

Employer's and Plan Administrator's Notice Obligations

The employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the ***employee***. This notice to the Plan Administrator does not occur when the Plan Administrator is the ***employer***. After plan administrators are notified of the qualifying event, they have 14 days to send the qualifying event notice. Qualified beneficiaries have 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage ends due to the qualifying event or the date of the qualifying-event notice, whichever is later.

The employer will also notify you and your dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the ***employee's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***employee's*** becoming enrolled in Medicare.

Election Procedures

You and your dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after you or your family member receive notice of the right to elect continuation coverage. *If you or your dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.*

You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage. In addition, a dependent may elect continuation coverage even if the covered employee does not elect continuation coverage.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group health plan or enrolled in Medicare.

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. Anyone who is not covered under the Plan on the day before the qualifying event is generally not entitled to continuation coverage. Exceptions include: 1) when coverage was eliminated in anticipation of a divorce or legal separation the later divorce or legal separation is considered a qualifying event even though the ex-spouse/spouse lost coverage earlier: and 2) a child born to or placed for adoption with the covered employee during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.

Qualified beneficiaries are provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active employees or their dependents, then continuation coverage will be modified in the same way. Examples: 1) If the employer offers an open enrollment period that allows active employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation are allowed to switch plans as well; and 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation are afforded this same right.

Maximum Coverage Periods

Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage Before the End of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

18 Months. If you or your dependent loses coverage due to the ***employee's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

36 Months. If a dependent loses coverage because the ***employee*** became enrolled in Medicare or because of a loss of dependent status under the Plan, then the maximum coverage period (for spouse and dependent child) is three (3) years from the date of the qualifying event.

Indefinite Under Minnesota Law. If you or your dependents lose coverage because of the ***employee's*** total disability (as defined above), then the maximum coverage period is indefinite. If a dependent loses group health coverage because of the ***employee's*** death, divorce or legally separate, then the maximum coverage period (for ex-spouse/spouse and dependent child) is indefinite.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a dependent's disability, the premiums for continuation can be up to 150% of the group rate for months 19-29 if the disabled dependent is covered. If the qualifying event for continuation is the ***employee's*** totally disability, the administration fee is not permitted. All premiums are paid directly to the employer.

Extension of Maximum Coverage Periods

Maximum coverage periods of 18 or 36 months can be extended in certain circumstances.

- ***Disability Extension:*** This extension is applicable when the qualifying event is the ***employee's*** termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If your dependent who is a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

  Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***employee's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or

the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the ***employee's*** termination of employment or reduction of hours.)

Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month following 30 days after a final determination by the SSA that the formerly disabled qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.

- ***Multiple Qualifying Events:*** This extension is applicable when the initial qualifying event is the ***employee's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month or an indefinite maximum coverage period. The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  When a second qualifying event occurs that gives rise to a 36-month maximum coverage period for the dependent, then the maximum coverage period (for the dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension will occur.

  When a second qualifying event occurs that gives rise to an indefinite maximum coverage period for the dependent, then the maximum coverage period (for the dependent) becomes indefinite. For an indefinite maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given, no extension of continuation coverage will occur.

- ***Pre-Termination or Pre-Reduction Medicare Enrollment:*** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the ***employee's*** Medicare enrollment. The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  If the qualifying event occurs within 18 months after the ***employee*** becomes enrolled in Medicare, regardless of whether the ***employee's*** Medicare enrollment is a qualifying event (causing a loss of coverage under the group Plan), the maximum period of continuation for the ***employee's*** dependents who are qualified beneficiaries is three (3) years from the date the ***employee*** became enrolled in Medicare. Example: ***Employee*** becomes enrolled in Medicare on January 1. ***Employee's*** termination of employment is May 15. The ***employee*** is entitled to 18 months of continuation from the date coverage is lost. The ***employee's*** dependents are entitled to 36 months of continuation from the date the ***employee*** is enrolled in Medicare.

  If the qualifying event is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

- ***Employer's Bankruptcy:*** The bankruptcy rule technically is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the Plan, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the ***employee*** and dependents will automatically terminate when any one of the following events occurs:

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.

- After electing continuation, you or your dependents become covered under another group health plan that has no exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- If during a 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered ***employees*** or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

When termination takes effect earlier than the end of the maximum period of continuation coverage, a notice will be sent from the Plan Administrator. The notice will contain the reason continuation coverage has been terminated, the date of the termination, and any rights to elect alternative coverage that may be available.

Retirees of Political Subdivisions

A retiree of a political subdivision who is receiving a disability benefit or an annuity from a Minnesota public pension plan (other than a volunteer firefighter plan), or who has met age and service requirements necessary to receive an annuity from such a plan along with the retiree's dependents, may continue coverage indefinitely.

Children Born to or Placed for Adoption With the Covered Employee During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***employee*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***employee*** is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption, or placement for adoption as outlined in the Eligibility section, and it lasts for as long as continuation coverage lasts for other family members of the ***employee***.

Open Enrollment Rights and Special Enrollment Rights

Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. Special enrollment rights apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your dependent's address changes, you must notify the Plan Administrator in writing (the Plan Administrator may mail you or your dependent important continuation notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you or your dependent must notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled ***employee*** or family member is no longer disabled.

Special Second Election Period

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about

these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Questions

If you have general questions about continuation of coverage, please call the telephone number on the back of your ID card for assistance.

Overview

The following chart is an overview of the information outlined in the previous sections. For more detail refer to the previous sections.

Qualifying Event / Extension	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and dependents	Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.
Divorce or legally separate	Ex-spouse/spouse and any dependent children who lose coverage	Earlier of: 1. Enrollment date in other group coverage; or 2. Date coverage would otherwise end.
Death of employee	Surviving spouse and dependent children	Earlier of: 1. Enrollment date in other group coverage; or 2. Date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
Dependents lose eligibility due to the employee's enrollment in Medicare	All dependents	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
Retirees of the employer filing	Retiree	Lifetime continuation.

Qualifying Event / Extension	Who May Continue	Maximum Continuation Period
Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Total disability of employee	Employee and dependents	Earlier of: 1. Date total disability ends; or 2. Date coverage would otherwise end.
Extensions to 18-month maximum continuation period: Total disability of dependent(s)	Disabled dependent and all other covered family members	Earliest of: 1. 29 months after the employee leaves employment; or 2. Date total disability ends; or 3. Date coverage would otherwise end.

Conversion/InterPlan Transfer (IPT)

You or your dependents who are Minnesota residents may convert your coverage to an individual qualified plan. If you or your dependents reside outside of Minnesota, you may request an IPT to another Blue Cross and/or Blue Shield Plan. Conversion and IPT apply if coverage ends because:

1. you become ineligible;
2. your continuation coverage is exhausted;
3. no continuation coverage is available to you; or
4. the Plan ends and is not replaced by continuous group coverage.

If your coverage ends because you become ineligible or leave the Plan, you must apply for conversion/IPT coverage within 62 days after your coverage (or continuation) ends. If your coverage ends because the Plan ends, you must apply for conversion/IPT coverage within 62 days after receiving notice of cancellation of the Plan.

Conversion coverage/IPT and premiums will not be the same as the Plan. Evidence of good health is not required. Regardless of the reason coverage ends, you are not eligible for conversion/IPT if you do not apply within 62 days of losing group coverage.

COORDINATION OF BENEFITS

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under this Plan are not reduced if the Order of Benefits Rules require this Plan to pay first. Your benefits under this Plan may be reduced if another plan pays first.

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that 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. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;

   b. coverage under a government plan or one required or provided by law; or

   c. individual coverage.

   "Plan” 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). "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

   "Plan" does not include hospital, specified accident, specified disease, or limited benefit insurance policies.

2. "This Plan" means the part of the Plan document that provides health care benefits.

3. "Primary Plan/Secondary Plan" is determined by the Order of Benefits Rules.

   When This Plan is a Primary Plan, its benefits are determined before any 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 you are covered under more than two (2) plans, this Plan may be a Primary Plan as to some plans, and may be a Secondary Plan to other plans.

   Notes:

   a. If you are covered under This Plan and Medicare: This Plan will comply with Medicare Secondary Payor (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a primary Plan and which is a Secondary Plan. Medicare will be primary and This Plan will be secondary only to the extent permitted by MSP rules. When Medicare is the Primary Plan, this Plan will coordinate benefits up to Medicare's allowed amount.

   b. If you are covered under this Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefit’s Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. TRICARE will be primary and this Plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the Primary Plan, this Plan will coordinate benefits up to TRICARE's allowed amount.

4. "Allowable Expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable Expense" does not include an item or expense that exceeds benefits that are limited by statute or This Plan. "Allowable Expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number 3 above).

   The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under This Plan.

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.

5. "Claim determination period" means a calendar year. However, it does not include any part of the year the person is not covered under This Plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

1. General. When a claim is filed under This Plan and another plan, This Plan is a Secondary Plan and determines benefits after the other plan, unless:

   a. the other plan has rules coordinating its benefits with This Plan's benefits; and

   b. the other plan's rules and This Plan's rules, in part 2. below, require This Plan to determine benefits before the other plan.

2. Rules: This Plan determines benefits using the first of the following rules that applies:

   a. Nondependent/dependent. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

   b. Dependent child of parents not separated or divorced. When This Plan and another plan cover the same child as a dependent of different persons, called "parents":

      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan 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 determines the order of benefits.

   c. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, this Plan determines benefits in this order:

      1) first, the plan of the parent with physical custody of the child;
      2) then, the plan that covers the spouse of the parent with physical custody of the child; and,
      3) finally, the plan that covers the parent not having physical custody of the child.

      However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

   d. Active/inactive employee. The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that 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, then this rule is ignored.

   e. Longer/shorter length of coverage. If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

Effect on Benefits of This Plan

1. When this section applies:

   When the Order of Benefits Rules above require This Plan to be a Secondary Plan, this part applies. Benefits of This Plan may be reduced.

2. Reduction in This Plan's benefits:

   When the sum of:

   a. the benefits payable for allowable expenses under This Plan, without applying coordination of benefits; and

   b. the benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of This Plan are reduced so that benefits payable under all plans do not exceed allowable expenses.

      When benefits of This Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Plan. Benefits saved by This Plan due to coordination of benefits saving (credit reserve) are available for payment on future claims during this Plan year. Credit reserve will start over for the next Plan year.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If this happens, This Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under This Plan. This 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 This Plan pays more than it should have paid under these coordination of benefit rules, This Plan may recover the excess from any of the following:

1. the persons This Plan paid or for whom This Plan has paid;
2. insurance companies; and
3. other organizations.

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

REIMBURSEMENT AND SUBROGATION

If the Plan pays medical benefits for medical or dental expenses you incur as a result of any act of any person, and you later obtain compensation, you are obligated to reimburse the Plan for the benefits paid. If you or your dependents receive benefits under this Plan arising out of illness or injury for which a responsible party is or may be liable, the Plan is also entitled to subrogate against any person, corporation and/or other legal entity, or any insurance coverage, including both first- and third-party automobile coverages. The Plan's right to reimbursement and subrogation is subject to you obtaining full recovery, as explained in Minnesota statutes 62A.095 and 62A.096. The Plan's right to reimbursement and subrogation is subject to reduction for the Plan's pro rata share of costs, disbursements, and reasonable attorney fees incurred in obtaining the recovery unless the Plan Administrator is separately represented by our own attorney.

Notice Requirement

You must provide timely written notice to the Plan Administrator of the pending or potential claim, if you make a claim against a third party for damages that include repayment for medical and medically-related expenses incurred for your benefit. The Plan Administrator, at its option, may take appropriate action to preserve its rights under this Reimbursement and Subrogation section, including the right to intervene in any lawsuit you have commenced.

The Plan Administrator may delegate such function to the Claims Administrator.

Duty to Cooperate

You must cooperate with the Plan Administrator in assisting it to protect its legal rights under this provision. You agree that the limited period in which we may seek reimbursement or to subrogate does not commence to run until you or your attorney has given notice to us of your claim against a third party.

GENERAL PROVISIONS

Plan Administration

Plan Administrator

The general administration of the Plan and the duty to carry out its provisions is vested in the Employer. The board of directors will perform such duties on behalf of the Employer, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the Employer, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the Plan Administrator generally has final authority to administer the Plan.

Powers and Duties of the Plan Administrator

The Plan Administrator will have the authority to control and manage the operation and administration of the Plan. This will include all rights and powers necessary or convenient to carry out its functions as Plan Administrator. Without limiting that general authority, the Plan Administrator will have the express authority to:

1. construe and interpret the provisions of the Plan and decide all questions of eligibility;
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Plan;
3. prepare and distribute information to you explaining the Plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Plan; and
6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Plan.

Actions of the Plan Administrator

The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan, except with respect to claim determinations where final authority has been delegated to the Claims Administrator. All rules and decisions of the Plan Administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The Plan Administrator or the Employer may contract with one (1) or more service agents, including the Claims Administrator, to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such service agent(s) may also be given the authority to make payments of benefits under the Plan on behalf of and subject to the authority of the Plan Administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the Plan Administrator.

Nondiscrimination

The Plan shall not discriminate in favor of "highly compensated employees" as defined in Section 105(h) of the Internal Revenue Code, as to eligibility to participate or as to benefits.

Termination or Changes to the Plan

No agent can legally change the Plan or waive any of its terms.

The Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Internal Revenue Code) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan, provided however, that no modification or amendment shall divest an employee of a right to which he or she is entitled under the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the School Board. The Plan Administrator will communicate any adopted changes to the employees.

Funding

This Plan is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided through a special arrangement with your local service cooperative according to the terms of its agreement with the Claims Administrator. Your contributions toward the cost of coverage under the Plan will be determined by the employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, any questions, claims, disputes, or litigation concerning or arising from the Plan will be governed by the laws of the state of Minnesota.

Privacy of Protected Health Information

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a health care plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable basis to believe that it could be used to identify you.

Restrictions on the Use and Disclosure of Protected Health Information

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

Separation Between the Employer and the Plan

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI; Superintendent. This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the Plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each employee or workforce member and will reduce any harmful effects of the violation.

GLOSSARY OF COMMON TERMS

Please refer to the Benefit Chart for specific benefit and payment information.

Term	Definition
90dayRx	Participating 90dayRx Retail Pharmacies and Mail Service Pharmacy used for the dispensing of a 90-day supply of long-term prescription drug refills.
Admission	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
Advanced Practice Nurses	Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
Allowed Amount	The amount upon which the Claims Administrator bases payment for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same covered service. All benefits are based on the allowed amount, except as specified in the Benefit Chart. **The Allowed Amount for Participating Providers** For Primary and Extended Network Providers, the allowed amount is the negotiated amount of payment that the Primary and Extended Network Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Primary and Extended Network Providers as a result of expected settlements or other factors. The negotiated amount of payment with Primary and Extended Network Providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per-service allowed amount for such covered services. Through settlements, and other special arrangements with Primary and Extended Network Providers, the Claims Administrator may prospectively or subsequently pay a different amount to Primary and Extended Network Providers. Such payments will not affect or cause any change in the amount you paid at the time your claim was processed. **Qualifications Applicable to All Nonparticipating Providers** In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this allowed amount is a usual, customary, or reasonable charge from a provider. The allowed amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the allowed amount is subject to all of the Claims Administrator's business rules as defined in the Claims Administrator Provider Policy and Procedure Manual. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

Term	Definition
	The Allowed Amount for Nonparticipating Providers in Minnesota For Nonparticipating Provider services in Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; or (4) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. **The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota** For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options, to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by the Host Blue plan; or (5) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.. **Special Circumstances** When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the allowed amount and the provider's billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. This reimbursement also applies when you receive care in a nonparticipating hospital as a result of a medical emergency. If you have questions about the benefits available for services to be provided by a Nonparticipating Provider, you will need to speak with your provider and you may call the Claims Administrator Customer Service at the telephone number on the back of your member ID card for more information.
Artificial Insemination (AI)	The introduction of semen from a donor (which may have been preserved as a specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.
Assisted Reproductive Technologies (ART)	Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine, or artificial insemination), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.
Attending Health Care Professional	A health care professional with primary responsibility for the care provided to a sick or injured person.
Average Semiprivate Room Rate	The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

Term	Definition
Behavioral Health Care Treatment	Treatment for mental health disorders and substance abuse/addition diagnoses as listed in the most recent edition of the *International Classification of Diseases.* Does not include developmental disability.
Behavioral Health Select Network Provider	A health professional that participates in a special network for the provision of mental health or substance abuse treatment services.
Benefit Chart	The section that lists benefits and covered services.
BlueCard Program	A Blue Cross and Blue Shield program which allows employees and dependents to access covered health care services while traveling outside the state of Minnesota. Employees and dependents must use Participating Providers of a Host Blue and show their membership ID to secure BlueCard Program access.
Calendar Year	The period starting on January 1st of each year and ending at midnight December 31st of that year.
Care/Case Management Plan	A plan for health care services developed for a specific patient by one of our care/case managers after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.
Certification of Coverage	A form which will be issued when health coverage is terminated under this certificate. The Certification of Coverage form will contain the necessary information a new health plan will need to apply the appropriate credit toward the new health plan's preexisting condition limitation period.
Claims	A claim is a written submission from your provider (or from you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is a non-covered benefit, the claim will deny, meaning no payment is allowed. Providers are required to use certain codes to explain the care they give you. The provider's medical record must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to talk to your provider.
Claims Administrator	Blue Cross and Blue Shield of Minnesota (Blue Cross).
Coinsurance	The percentage of the amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from Primary and Extended Network Providers, coinsurance is calculated based on the lesser of the allowed amount or the Primary and Extended Network Provider's billed charge. Because payment amounts are negotiated with Primary and Extended Network Providers to achieve overall lower costs, the allowed amount for Primary and Extended Network Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for Primary and Extended Network Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage.

Term	Definition
	For covered services from Nonparticipating Providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount. Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties. Coinsurance Example: You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim: For instance, when the Claims Administrator pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over the Claims Administrator's allowed amount when a Nonparticipating Provider is used. For example, if a Nonparticipating Provider ordinarily charges $100 for a service, but the Claims Administrator's allowed amount is $95, the Claims Administrator will pay 80% of the allowed amount ($76). You must pay the 20% coinsurance on the Claims Administrator's allowed amount ($19), plus the difference between the billed charge and the allowed amount ($5), for a total responsibility of $24. Remember, if Primary and Extended Network Providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Claims Administrator's allowed amount. If Nonparticipating Providers are used, your out-of-pocket costs will be higher as shown in the example above.
Compound Drug	A prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution is added to the active ingredient.
Comprehensive Pain Management Program	A multidisciplinary program including, at a minimum, the following components: 1. a comprehensive physical and psychological evaluation; 2. physical/occupation therapies; 3. a multidisciplinary treatment plan; and, 4. a method to report clinical outcomes.
Continuous Qualifying Creditable Coverage	The maintenance of continuous and uninterrupted qualifying creditable coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous qualifying creditable coverage if the individual applies for coverage within 63 days of the termination of his/her qualifying creditable coverage.
Copay	The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.
Cosmetic Services	Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Term	Definition
Covered Services	A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.
Custodial Care	Services to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.
Cycle	One (1) partial or complete fertilization attempt extending through the implantation phase only.
Day Treatment	Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.
Deductible	The amount you must pay toward the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each person and family are shown on the Benefit Chart. Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.
Dependent	Your spouse, child to the dependent child age limit specified in the Eligibility section, child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the Eligibility section, grandchild who meets the eligibility requirements as defined in the Eligibility section to the age specified in the Eligibility section, disabled dependent or dependent child as defined in the Eligibility section, or any other person whom state or federal law requires be treated as a dependent.
Drug Therapy Supply	A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.
Durable Medical Equipment	Medical equipment prescribed by a physician that meets each of the following requirements: 1. able to withstand repeated use; 2. used primarily for a medical purpose; 3. generally not useful in the absence of illness or injury; 4. determined to be reasonable and necessary; and, 5. represents the most cost-effective alternative.
E-Visit	An online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
Emergency Hold	A process defined in Minnesota law that allows a provider to place a person, who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.
Enrollment Date	The first day of coverage, or if there has been a waiting period, the first day of the waiting period (typically the date employment begins).

Term	Definition
Extended Network Provider	A participating provider in Minnesota that has entered into a specific network contract with the Claims Administrator but is not considered a Primary Network Provider. Outside Minnesota, Extended Network Providers are providers in the BlueCard Traditional Network.
Extended Hours Skilled Nursing Care	Extended hours skilled nursing care, also referred to as private duty nursing care, are complex nursing care services provided in a member's home. Extended hours skilled nursing care services provide complex, direct skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and not intended to be provided on a permanent, ongoing basis.
Facility	A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located, to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, or a home health agency when services are billed on a facility claim.
Family Therapy	Behavioral health therapy intended to treat an individual within the context of family relationships. The focus of the treatment is to identify problems or conflicts and to set specific goals for resolving them.
Foot Orthoses	Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.
Freestanding Ambulatory Surgical Center	A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor’s office, or other health care professional’s office.
Group Home	A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.
Group Therapy	Behavioral health therapy conducted with multiple patients.
Halfway House	Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.
Health Care Professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dieticians and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
Home Health Agency	A Medicare-approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.

Term	Definition
Hospice Care	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.
Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.), or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Host Blue	A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that require such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.
Illness	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
Infertility Testing	Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.
Inpatient Care	Care that provides 24-hour-a-day professional registered nursing (R.N) services for short-term medical and behavioral health services in a hospital setting.
Intensive Outpatient Programs (IOP)	A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.
Intermittent Skilled Nursing Care	Intermittent skilled nursing care is defined as a visit by a registered nurse or licensed practical nurse of up to four (4) consecutive hours in duration.
Intrauterine Insemination (IUI)	A specific method of artificial insemination in which semen is introduced directly into the uterus.
Investigative	A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself: 1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; 2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients); 3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Term	Definition
	Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.
Late Entrant	If applicable, an eligible employee or dependent who requests enrollment under the Plan following the enrollment period after which the individual first became eligible for coverage. Late entrants will be subject to a preexisting condition limitation period, with credit for prior continuous qualifying creditable coverage. An individual will not be considered a late entrant if: 1. the individual was covered under qualifying creditable coverage at the time the individual was eligible to enroll for coverage under this Plan, declined enrollment on that basis, and presents to the Claims Administrator a certificate of termination of the qualifying creditable coverage within 30 days; 2. the individual is applying for coverage within 30 days of the exhaustion of the maximum continuation period provided by state and federal law; 3. the individual is applying for coverage within 30 days of losing eligibility under other qualifying creditable coverage due to a divorce, legal separation, death, termination of employment, reduction in hours, or employer contributions toward the coverage was terminated; 4. the individual is a new spouse of an eligible employee applying for coverage within 30 days of becoming legally married; 5. the individual is a new dependent of an eligible employee for whom coverage is being requested within 30 days of becoming a new dependent; 6. the individual elects a different plan during an open enrollment period; or, 7. the coverage being requested is the result of a court order for the addition of a dependent of an eligible employee within 30 days of the issuance of the order.
Lifetime Maximum	The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent's lifetime under all health plans sponsored by the Plan Administrator. The lifetime maximum does not include amounts which are your responsibility such as: deductibles, coinsurance, copays, and other amounts. Refer to the Benefit Chart for specific dollar maximums on certain services.
Mail Service Pharmacy	A pharmacy that dispenses prescription drugs through the U.S. Mail.
Marital/Couples Therapy	Behavioral health care services for the primary purpose of working through relationship issues.
Marital/Couples Training	Services for the primary purpose of relationship enhancements including, but not limited to: premarital education; or marriage/couples retreats, encounters or seminars.
Medical Emergency	Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

Term	Definition
Medically Necessary	Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
Medicare	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.
Mental Health Care Professional	A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice, that provides treatment for mental health disorders, substance abuse, or addiction.
Mental Illness	A mental disorder as defined in the *International Classification of Diseases*. It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.
Mobile Crisis Services	Face-to-face, short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.
Neuro-Psychological Examinations	Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.
Nonparticipating Provider	A provider that has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
OB/GYN Network	A provider network made up of obstetricians and gynecologists that female members may obtain certain services from without a referral from their PCC. Please consult your directory for a listing of these providers.
Opioid Treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Pocket Maximum	The most each person must pay each year toward the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the year. The Benefit Chart lists the out-of-pocket maximum amounts.

Term	Definition
Outpatient Behavioral Health Treatment Facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient Care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative Care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Partial Programs	An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.
Participating Pharmacy	A nationwide pharmaceutical provider that participates in a network for the dispensing of prescription drugs.
Participating Provider	A provider that has entered into a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Place of Service	Industry standard claim submission standards (established by the Medicare program) are used by clinic and hospital providers. Providers use different types of claim forms to bill for services based on the "place of service." Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.
Plan	The plan of benefits established by the Plan Administrator.
Plan Year	A 12-month period which begins on the effective date of the Plan and each succeeding 12-month period thereafter.
Preexisting Condition	A condition the Claims Administrator has determined existed within a specified time period preceding the enrollment date of your coverage. Conditions are considered to be preexisting if medical advice, diagnosis, care, or treatment was recommended or received. Preexisting condition does not include genetic information alone in the absence of a diagnosis for a condition related to the genetic information, or an existing pregnancy.
Preexisting Condition Limitation Period	The time period based on your enrollment date of your coverage during which services related to preexisting conditions will not be covered services under the Plan.
Preferred Drug List	The Claims Administrator's Preferred drug list is a list of prescription drugs and drug therapy supplies used by patients in an ambulatory care setting. Over-the-counter, injectable medications and drug therapy supplies are not included in your specified Preferred drug list unless they are specifically listed.

Term	Definition
Prescription Drug Out-of-Pocket Maximum	The most each person must pay toward the allowed amount for covered prescription drugs per year. After a person reaches the prescription drug out-of-pocket maximum, the Plan pays 100% of the allowed amount for prescription drugs services for the rest of the year. The Benefit Chart lists the prescription drug out-of-pocket maximum amount.
Prescription Drugs	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
Primary Care Clinic (PCC)	A physician or group of physicians who have entered into a network contract with the Claims Administrator to function as a health care entry point in providing or arranging to provide health services that are eligible for Primary Network benefits. You must choose your Primary Care Clinic (PCC) at the time of enrollment.
Provider	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered, to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.
Qualifying Creditable Coverage	Health coverage provided through an individual policy; a self-funded or fully-insured group health plan offered by a public or private employer; Medicare; MinnesotaCare; Medical Assistance (Medicaid); General Assistance Medical Care; the Minnesota Comprehensive Health Association (MCHA); TRICARE; Federal Employees Health Benefit Plan (FEHBP); Medical care program of the Indian Health Service of a tribal organization; a state health benefit risk pool; a Peace Corps health plan; Minnesota Employee Insurance Program (MEIP); Public Employee Insurance Program (PEIP); any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; the Children's Health Insurance Program (CHIP); or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioners of Commerce or Health.
Referral Provider	Any health professional to whom you are referred by a PCC.
Referral Service	A covered health service performed by a referral provider which is: 1. authorized in advance, in writing, by the PCC; and, 2. limited in scope, duration, or number of services authorized by the PCC.
Reproduction Treatment	Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.
Residential Behavioral Health Treatment Facility	A facility licensed under state law in the state in which it is located that provides treatment, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite Care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.

Term	Definition
Retail Health Clinic	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Retail Pharmacy	Any licensed pharmacy that you can physically enter to obtain a prescription drug.
Select Chiropractic Network Provider	A health professional that participates in a special network for the provision of chiropractic services.
Semiprivate Room	A room with more that one (1) bed.
Services	Health care services, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.
Skilled Care	Services that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a nonmedical person (or self-administered) without direct supervision of a licensed nurse shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.
Skilled Nursing Facility	A Medicare-approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.
Skills Training	Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment and the requirements of everyday independent living.
Smoking Cessation Drugs	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
Specialty Drugs	Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and, hemophilia.
Specialty Pharmacy Network	A nationwide pharmaceutical specialty provider that participates in a network for the dispensing of certain oral medications and injectable drugs.
Step Therapy	Step Therapy includes medications in specific categories or drug classes. If your physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication in the same or different drug class before the Step Therapy medication will be paid under the drug benefit.
Substance Abuse and/or Addictions	Alcohol, drug dependence or other addictions as defined in the most current edition of the *International Classification of Diseases*.

Term	Definition
Supervised Employees	Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.
Supply	Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year. Supplies do not include such things as: 1. incontinence liners/pads; 2. Q-tips; 3. adhesives; or, 4. informational materials.
Surrogate Pregnancy	An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise. Pregnancy may have been the result of conventional means, artificial insemination or assisted reproductive technologies.
Televideo Conferencing	Interactive audio and video communication, permitting real-time communication between a distant site health care professional and the patient whom is present and participating in the televideo visit at a remote facility.
Terminally Ill Patient	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
Therapeutic Camps	A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.
Therapeutic Day Care (Pre-School)	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.
Therapeutic Support of Foster Care	Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child’s improved functioning.
Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care surgical care diagnostic evaluation, giving medical advice, monitoring and taking medication.
Waiting Period	The period of time that must pass before you or your dependents are eligible for coverage under this Plan.