PREFERRED PROVIDER ORGANIZATION (PPO) HEALTH CARE PLAN

For Employees of:

Christensen Farms & Feedlots, Inc.

(herein called the Plan Administrator or the Employer)

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998, 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 the Claims Administrator 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. 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. **The Claims Administrator has determined that the prescription drug coverage offered through your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your prescription drug coverage is Creditable 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 November 15th through December 31st.
However, if you lose your current 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 coverage will not be affected. You may keep your current coverage with the Claims Administrator and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current prescription drug coverage, be aware that you and your dependents might not be able to get this coverage back, depending on your employer's eligibility policy. This risk might also extend to your medical coverage, so it is worthwhile to ask before enrolling in a Medicare drug plan.

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

You should also know that if you drop or lose your current coverage 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 1 percent 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 percent 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 November to join.

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

Contact Customer Service at the telephone number provided 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 coverage under this Plan changes. You may request a copy of this notice anytime.

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 Customer Service using the telephone number provided in the Customer Service section.
- 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; and
- initiate a legal proceeding when experiencing a problem with the Plan or its providers.

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 Christensen Farms & Feedlots, Inc. Preferred Provider Organization (PPO) Health Care Plan for benefits effective January 1, 2011.

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 Summary Plan Description are inapplicable for employee-only coverage.

This Plan, financed and administered by Christensen Farms & Feedlots, Inc., is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (BCBSM) 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 provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use In-Network Providers. In-Network Providers are providers that have entered into a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan to provide you quality health services at favorable prices. These providers are also referred to as Participating Providers.

The Plan also provides benefits for covered services you receive from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers include Out-of-Network Participating Providers and Nonparticipating Providers. Out-of-Network Participating Providers are health care professionals that have entered into a specific network contract with the Claims Administrator but do not participate in the special network mentioned above. Nonparticipating Providers have not entered into a network contract with the Claims Administrator. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed on the following page.

CUSTOMER SERVICE

Questions?	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for preadmission and emergency admission notification. Monday through Thursday: 7:00 am - 5:30 pm Central Time Friday: 9:00 am - 4:30 pm Central Time Hours are subject to change without prior notice.
Customer Service Telephone Number	Claims Administrator: (651) 662-5001 or toll free 1-800-531-6676
Blue Cross 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.
Stop-smoking program	Toll free 1-888-662-BLUE (2583) This number is used to enroll in the stop-smoking program

Stop-Smoking

Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583). A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months.

Dedicated Nurse Support

If you or an eligible family member has an ongoing condition like diabetes or heart disease – or you experience a major health event or illness—you may receive an invitation to take advantage of the voluntary and confidential Dedicated Nurse service. These health professionals look beyond your condition and at you as a whole person, matching telephone-based support and educational resources to your needs. A Dedicated Nurse gets to know you over time so you do not have to explain your situation every time you call.

If you think you are eligible to participate in the program and have not been invited, you may call the Customer Service telephone number listed on the back of your card. Once enrolled, you may choose not to participate at any time by calling the Customer Service telephone number listed on the back of your card.

Choosing A Health Care Provider

You may choose any eligible provider of health services for the care you need. The Plan may pay higher benefits if you choose In-Network Providers. Generally you will receive the best benefit from your health plan when you receive care from In-Network Providers.

The Plan features a large network of Participating Providers and each provider is an independent contractor and is not the Claims Administrator's agent.

In-Network Providers

When you choose these providers, you get the most benefits for the least expense and paperwork. In-Network Providers are providers in the Aware Network and the BlueCard PPO Network. In-Network Providers send your claims to the Claims Administrator and the Claims Administrator sends payment to the provider for covered services you receive. In-Network Providers may take care of notification requirements for you. Your provider directory lists In-Network Providers and may change as providers initiate or terminate their network contracts. For benefit information, refer to the Benefit Chart.

To receive the highest level of benefits for hospital/facility bariatric surgery services, you must use Blue Distinction Centers for Bariatric Surgery as your In-Network Provider.

Out-of-Network Providers

Out-of-Network Participating Providers

Out-of-Network Participating Providers are providers who have a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan (Participating Providers), but are not In-Network Providers. Out-of-Network Participating Providers may take care of notification requirements and may file claims for you. Verify with your provider if these are services they will provide for you. Most Out-of-Network Participating Providers accept the Claims Administrator's payment based on the allowed amount. The Claims Administrator recommends that you contact the Out-of-Network Participating Provider and verify if they accept the Claims Administrator's payment based on the allowed amount to determine if you will have additional financial liability.

Nonparticipating Providers

Nonparticipating Providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan. You are responsible for providing notification when necessary and submitting claims for services received from Nonparticipating Providers. Refer to the Liability for Health Care Expenses provision for a description of charges that are your responsibility. Please note that you may incur significantly higher financial liability when you use Nonparticipating Providers compared to the cost of receive care from In-Network Providers. In addition, participating facilities may have nonparticipating professionals practicing at the facility.

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 if services 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 the Claims Administrator, 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 an In-Network 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:

1. an acute condition;

2. a life-threatening mental or physical illness;

3. 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. a disabling or chronic condition in an acute phase or that is expected to last permanently;

5. you are receiving culturally appropriate services from a provider with special expertise in delivering those services; or

6. you 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 In-Network Providers

At your request, the Claims Administrator will assist you in making the transition from an Out-of-Network Provider to an In-Network 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 an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-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 an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-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 In-Network 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 the Claims Administrator and 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 an In-Network 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:

1. an acute condition;

2. a life-threatening mental or physical illness;

3. 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. a disabling or chronic condition in an acute phase or that is expected to last permanently;

5. you are receiving culturally appropriate services from a provider with special expertise in delivering those services; or

6. you 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 In-Network Providers

At your request, the Claims Administrator will assist you in making the transition from an Out-of-Network Provider to an In-Network 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.

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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 an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

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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

In-Network Providers

When you use In-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 the following amounts:

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

Out-of-Network Providers

Out-of-Network Participating Providers

When you use Out-of-Network Participating Providers for covered services, payment is still based on the allowed amount. Most Out-of-Network Participating Providers accept the Claims Administrator's payment based on the allowed amount. However, contact your Out-of-Network Participating Provider to verify if they accept the Claims Administrator's payment based on the allowed amount (to determine if you will have additional financial liability). In addition you are required to pay the following amounts:

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

Nonparticipating Providers

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 or the local Blue Cross and/or Blue Shield Plan, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. 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;
3. copays and coinsurance;
4. charges that exceed the benefit maximum level; and
5. charges for services that are not covered, including services that the Claims Administrator determines are not covered based on claims coding guidelines.

Inter-Plan Programs

Out-of-Area Services

The Claims Administrator 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 the Claims Administrator's 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 the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's 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. The Claims Administrator's 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, the Claims Administrator will remain responsible for fulfilling the Claims Administrator's 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 the Claims Administrator's 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 the Claims Administrator.

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 the Claims Administrator 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, the Claims Administrator would then calculate your liability for any covered health care services according to applicable law.

Nonparticipating Providers Outside the Claims Administrator's Service Area

1. Member Liability Calculation

When covered health care services are provided outside of the Claims Administrator's 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, the Claims Administrator 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 the Claims Administrator will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator 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 the Claims Administrator will make for the covered services as set forth in this paragraph.

General Provider Payment Methods

Participating Providers

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 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." Most 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"). 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. The Claims Administrator recommends that you verify with your 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 health care 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.

- **Non-Institutional or Professional (i.e., doctor visits, office visits) 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 percent) 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 member 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.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its member patients. In order to determine quality of care, certain factors are measured, such as member patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  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) 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; or
- the pharmacy's retail price; or
- the maximum allowable cost determined 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 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 are responsible for paying the difference between the Claims Administrator’s allowed amount and the Nonparticipating Provider’s billed charges. 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 this 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.

- **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)
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.

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 Claims Administrator's website.

Recommendations by Health Care Providers

Referrals are not required. 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 an Out-of-Network Provider or the recommended services may be covered at a lesser level of benefits or 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 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 or intentional misrepresentation of material fact including, but not limited to: submitting fraudulent misstatements or omissions 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 exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification, and 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.

Minnesota In-Network Providers are required to obtain prior authorization for you. You are required to obtain prior authorization when you use In-Network Providers outside Minnesota and Out-of-Network Providers. However, 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.

The prior authorization list* is subject to change due to changes in the Claims Administrator's medical policy. The most current list is available on the Claims 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; and mastopexy
- **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; and 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; and botulinum toxin injections for off-label usage
- **Durable Medical Equipment (DME), prosthetics and supplies including but not limited to:** 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; and 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 the Claims Administrator requires prior authorization**
- **Hospice care**
- **Humanitarian Use Devices** (defined as devices that are intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year, classified under the FDA Humanitarian Device Exemption)
- **Imaging services including, but not limited to:** breast magnetic resonance imaging (MRI); and CT colonography (virtual colonoscopy)
- **Surgical procedures including, but not limited to:** bariatric surgery; hyperhidrosis surgery; sex reassignment surgery; spinal cord stimulators; surgical treatment of obstructive sleep apnea and upper airway resistance syndrome; vagus nerve stimulation (for all conditions); spinal fusion; pelvic floor stimulation; ventricular assist devices
- **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 to ensure accuracy. 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 the Claims Administrator that you will be admitted for inpatient hospitalization services. This notice is required at least five (5) days in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization. If the Claims Administrator is not notified, a penalty will apply. The Claims Administrator reduces the allowed amount for the admission by 25 percent. This means that without preadmission notification, you will pay a greater portion of the charges.

Minnesota In-Network Providers are required to provide preadmission notification for you.

If you are going to receive nonemergency care from In-Network Providers outside Minnesota and Out-of-Network Providers you are required to provide preadmission notification to the Claims Administrator. However, some of these providers may provide preadmission notification 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. 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. Hospitals 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 concurrent/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.

Minnesota In-Network Providers are required to provide preadmission certification for you.

If you are going to receive nonemergency care from In-Network Providers outside Minnesota and Out-of-Network Providers, you are required to provide preadmission certification to the Claims Administrator. However, 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. 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 provided 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.

Minnesota In-Network Providers are required to provide emergency admission notification for you.

If you receive care from In-Network Providers outside Minnesota and Out-of-Network Providers, you are required to provide emergency admission notification to the Claims Administrator. However, 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

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this Plan. The claims procedures described in this SPD are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this Plan. If the Claims Administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this Plan, no benefits will be payable under this Plan. All claims and questions regarding claims should be directed to the Claims Administrator.

Types of Claims

A “claim” is any request for a Plan benefit made in accordance with these claims procedures. You become a “claimant” when you make a request for a Plan benefit in accordance with these claims procedures. There are four types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-service Claim

A “Pre-service Claim” is any request for a Plan benefit where the Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Urgent Care Claim

An “Urgent Care Claim” is a special type of Pre-service Claim. An “Urgent Care Claim” is any Pre-service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-service Claims could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator will determine whether a Pre-service Claim involves urgent care, provided that, if a physician with knowledge of the claimant’s medical condition determines that a claim involves urgent care, the claim will be treated as an Urgent Care Claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the Claims Administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A “Concurrent Care Claim" arises when the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Claims Administrator has approved. If the Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claim

A “Post-service Claim” is any request for a Plan benefit that is not a Pre-service Claim or an Urgent Care Claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an Urgent Care Claim. If the urgency subsides, it may be re-characterized as a Pre-service Claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the Claims Administrator.

Filing Claims

Except for Urgent Care Claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for Plan benefits to the Claims Administrator. A claimant is not responsible for submitting claims for services received from In-Network or Out-of-Network Participating Providers. These providers will submit claims directly to the local Blue Cross and Blue Shield Plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from Nonparticipating Providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the Claims Administrator. The necessary forms may be obtained by contacting the Claims Administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Urgent Care Claims

An Urgent Care Claim may be submitted to the Claims Administrator by telephone at (651) 662-5001 or toll free at 1-800-531-6676.

Pre-service Claims

A Pre-service Claim (including a Concurrent Care Claim that is also a Pre-service Claim) is considered filed when the request for approval of treatment or services is made and received by the Claims Administrator.

Post-service Claims

A Post-service Claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly-Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed Pre-service Claim, the Claims Administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed Urgent Care Claim, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

Timeframes for Deciding Claims

Urgent Care Claims

The Claims Administrator will decide an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-service Claims

The Claims Administrator will decide a Pre-service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the Claims Administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for Pre-service, Urgent Care, or Post-service Claims.

Concurrent Care Reduction or Early Termination

The Claims Administrator's decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The Claims Administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The Claims Administrator will decide a Post-service Claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the Claims Administrator is not able to decide a Pre-service or Post-service Claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the Claims Administrator's control that justify the extension and the date by which the Claims Administrator expects to render a decision. No extension of time is permitted for Urgent Care Claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The Claims Administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a Pre-service or Post-service Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the Claims Administrator. The Claims Administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.

Notification of Initial Benefit Decision

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether the decision is adverse or not. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The Claims Administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;

2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;

3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;

4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The Claims Administrator will give no deference to the initial benefit decision;

6. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;

7. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;

8. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice;

9. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator;

10. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;

11. The Claims Administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and

12. The Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Claims Administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the Claims Administrator by telephone at (651) 662-5001 or toll-free 1-800-531-6676. The Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The Claims Administrator will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The Claims Administrator will decide the appeal of a Pre-service Claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-service Claims

The Claims Administrator will decide the appeal of a Post-service Claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-service, Urgent Care, or Post-service Claims described above, as appropriate to the request.

Notification of Appeal Decision

The Claims Administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. Unless these procedures are deemed to be exhausted, the decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced.**

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-service or Post-service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

External Review

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. You must pay a filing fee of $25.00 at the time you request an external review. This filing fee will be refunded to you in the event the adverse benefit decision is overturned. (Filing fees are capped at $75.00 per plan year.)

1. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

    a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;

    b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;

    c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and

    d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If you request is not complete, but eligible, the Claims Administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

    The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

    The Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

    The IRO will review all of the information and documents timely received and is not bound by the Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

    a. your medical records;

    b. the attending health care professional's recommendation;

    c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;

    d. the terms of the your summary plan description plan;

    e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by the claims administrator; and

g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:

   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When the Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by the Claims Administrator’s prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO’s notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.

Additional Provisions

Authorized Representative

A claimant may appoint an “authorized representative” to act on his or her behalf with respect to a claim or an appeal of an adverse benefit determination. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Claims Administrator. However, in connection with an Urgent Care Claim, the Claims Administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the Claims Administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

Claims Payment

When a claimant uses In-Network or Out-of-Network Participating Providers, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her 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 child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for certain institutional and medical/surgical providers outside the state of Minnesota.

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.

Release of Records

Claimants agree to allow all health care providers to give the Claims Administrator needed information about the care that they provide to them. 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. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Right of Examination

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant's failure to comply with this request may result in denial of the claimant's claim.

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 Summary Plan Description and must be medically necessary.

Benefit Features, Limitations, and Maximums

Networks:	
• In-Network Providers	Aware Network Providers and BlueCard PPO Network Providers
Benefit Features	**Your Liability**
Prescription drugs	
Retail pharmacy	
• Generic drug copay	$15.00 per prescription
• Flex Rx Formulary brand name drug copay	$30.00 per prescription
• Nonformulary brand name drug copay	$45.00 per prescription
• Specialty drug copay	$125 per prescription
90dayRx including participating retail 90dayRx pharmacy and mail service pharmacy	
▪ Generic drug copay	$37.50 per prescription
▪ FlexRx Formulary brand name drug copay	$75.00 per prescription
▪ Nonformulary brand name drug copay	$112.50 per prescription

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.)

(Does not include prescription drug copays)

• In-Network Providers	$350 per person per calendar year
	$750 per family per calendar year
• Out-of-Network Providers	$500 per person per calendar year
	$1,000 per family per calendar year

The amounts accumulated toward the deductibles are applied to services provided by both In-Network Providers and Out-of-Network Providers.

Amounts accumulated toward the In-Network deductible also accumulate toward the Out-of-Network deductible. When the In-Network deductible is satisfied, covered services from In-Network Providers will be paid at the covered percentage.

Amounts accumulated toward the Out-of-Network deductible also accumulate toward the In-Network Deductible. When the Out-of-Network deductible is satisfied, the Claims Administrator consider both the In-Network and Out-of-Network deductibles satisfied and covered services from all providers will be paid at the covered percentage.

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
Note: Price differences between brand name and generic drugs may be your responsibility in certain instances. This amount is your responsibility and is not credited towards any out-of-pocket maximum.	
• In-Network Providers	$2,000 per person per calendar year
	$4,000 per family per calendar year
• Out-of-Network Providers	$3,000 per person per calendar year
	$5,000 per family per calendar year

The amounts accumulated toward the out-of-pocket maximum are applied to services provided by both In-Network Providers and Out-of-Network Providers.

Amounts accumulated toward the In-Network out-of-pocket maximum also accumulate toward the Out-of-Network out-of-pocket maximum. When the In-Network out-of-pocket maximum is satisfied, covered services from In-Network Providers will be paid at 100% of the Allowed Amount.

Amounts accumulated toward the Out-of-Network out-of-pocket maximum also accumulate toward the In-Network Out-of-Pocket Maximum. When the Out-of-Network out-of-pocket maximum is satisfied, we consider both the In-Network and Out-of-Network out-of-pocket maximums satisfied and covered services from all providers will be paid at 100% of the Allowed Amount.

The following items are applied toward the medical out-of-pocket maximum:
1. coinsurance;
2. deductibles; and
3. penalties for not giving the Claims Administrator preadmission notification.

The following items are NOT applied toward the medical out-of-pocket maximum:
1. prescription drug copays; and
2. deductible carryover.

Lifetime Maximum	
• Total benefits paid to all providers combined	Unlimited

Benefit Descriptions

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

Ambulance

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the condition • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	80% after you pay the deductible.	80% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and 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

Bariatric Surgery

The Plan Covers:	Blue Distinction Centers for Bariatric Surgery℠	Out-of-Network Providers
• Medically necessary **inpatient hospital/facility** services for bariatric surgery from admission to discharge ▪ 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 ▪ Lab and diagnostic imaging • Medically necessary outpatient hospital/facility services for bariatric surgery: ▪ Scheduled surgery/anesthesia ▪ Lab and diagnostic imaging ▪ All other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery	80% after you pay the deductible.	**Non-Blue Distinction In-Network Providers:** 60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount. **Nonparticipating Providers:** When you use a Nonparticipating Provider, there is **NO COVERAGE**.

NOTES:

- **Please see the Notification Requirements section.**
- **For professional services related to eligible bariatric surgery services, refer to Physician Services.**
- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.
- As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.
- Prior authorization is required for bariatric surgery procedures. The Claims Administrator requests prior authorizations be submitted in writing to:

  Blue Cross and Blue Shield of Minnesota
  Medical Review Department
  P.O. Box 64265
  St. Paul, MN 55164

- For a list of Blue Distinction Centers for Bariatric Surgery call Customer Service or visit the Claims Administrator's website.

- For pre and post-operative bariatric services, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Non-Blue Distinction Participating Provider means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan but is not in the Blue Distinction Network.

NOT COVERED:

- services you receive from a Nonparticipating Provider
- please refer to the General Exclusions section

Behavioral Health Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network 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) • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy • Inpatient health care professional charges • 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% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- 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 is provided for diagnosable mental health conditions, including autism and eating disorders.
- 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.
- For home health related services, refer to Home Health Care.
- 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 calls, except for eligible E-Visits.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- services for mental illness 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; services that are not considered medically necessary include, but are not limited to, the following: 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, incarceration, 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:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ family therapy ▪ opioid treatment • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ Intensive Outpatient Programs (IOP) and related aftercare services • Inpatient health care professional charges • Inpatient hospital/residential behavioral health treatment facility charges	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- 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, 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 calls, except for eligible E-Visits.

NOT COVERED:

- services for substance abuse or addictions 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; services that are not considered medically necessary include, but are not limited to, the following: 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, incarceration, 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:	In-Network Providers	Out-of-Network Providers
• Chiropractic care	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.

NOT COVERED:

- 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 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:	In-Network Providers	Out-of-Network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth • Treatment of cleft lip and palate to age 18 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	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- 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, treatment and/or restoration of a sound and healthy natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- 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, refer to Hospital Inpatient or Hospital Outpatient.
- For medical services, 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 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.
- 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 year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound and healthy natural tooth.

NOT COVERED:

- 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 and any associated services and/or charges, except as specified in the Benefit Chart
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as specified in the Benefit Chart
- accident-related dental services initiated after 12 months from the date of injury or 12 months of your effective date of coverage under this Plan or occurring more than 24 months after the date of initial treatment
- 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
- all orthodontia, except as specified in the Benefit Chart
- oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth, except as specified in the Benefit Chart
- root canal therapy, except as specified in the Benefit Chart
- 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:	In-Network Providers	Out-of-Network Providers
• Outpatient hospital/facility emergency room charges • Outpatient health care professional charges	80% after you pay the deductible.	80% after you pay the deductible.

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.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- For inpatient services, refer to Hospital Inpatient and Physician Services.
- For urgent care visits, refer to Hospital Outpatient and Physician Services.
- For take home prescription drugs, refer to Prescription Drugs and Insulin.

NOT COVERED:

- please refer to the General Exclusions section

Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care ordered in writing by a physician and provided by Medicare approved or other preapproved home health agency employees, including, but not limited to: ▪ licensed registered nurse; ▪ licensed registered physical therapist; ▪ master's level clinical social worker; ▪ registered occupational therapist; ▪ certified speech and language pathologist; ▪ medical technologist; or ▪ licensed registered dietician • Services of a home health aide or 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% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- For prescription drugs, refer to Prescription Drugs and Insulin.
- 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, 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
- please refer to the General Exclusions section

Home Infusion Therapy

The Plan Covers:	In-Network Providers	Out-of-Network 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 ▪ monitor your 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% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**

NOT COVERED:

- 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:	In-Network Providers	Out-of-Network Providers
• Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice, including: ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- Prior approval is recommended for entrance into the hospice benefit, for any inpatient admission while the patient is receiving hospice benefits, for any patient living beyond six (6) months, and for determination of coverage for services unrelated to the terminal condition.
- Benefits are restricted to terminally ill 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.
- Coverage for respite care is limited to not more than five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- 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:

- room and board expenses in a non-approved residential hospice facility
- please refer to the General Exclusions section

Hospital Inpatient

The Plan Covers:	In-Network Providers	Out-of-Network 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 • Lab and diagnostic imaging • Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- The Plan covers kidney and cornea transplants. For other kinds of transplants, 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.
- For take home prescription drugs, refer to Prescription Drugs and Insulin.

NOT COVERED:

- communication services provided on an outpatient basis or in the home
- 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
- please refer to the General Exclusions section

Hospital Outpatient

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

NOTES:

- **Please see the Notification Requirements section.**
- 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 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.
- For take home prescription drugs, refer to Prescription Drugs and Insulin.

NOT COVERED:

- please refer to the General Exclusions section

Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Health care professional services for: ▪ delivery in a hospital/facility ▪ postpartum care • Hospital/facility services for inpatient hospital care	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- For prenatal care benefits, refer to Preventive Care.
- Refer to the Eligibility section to determine when baby's coverage will begin.
- Group health plans such as this Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may under federal law, require that a provider obtain authorization from the Claims Administrator for prescribing a length of stay greater than 48 hours (or 96 hours).
- The Plan covers one (1) home health care visit within four (4) days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See Home Health Care.

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, and 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:	In-Network Providers	Out-of-Network 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 • 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. • Custom foot inserts only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet.	80% after you pay the deductible.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- **Please see the Notification Requirements section.**
- 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, refer to Prescription Drugs and Insulin.

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
- 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, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as provided in the Benefit Chart
- prescription drugs for or related to assisted reproductive technology (ART)
- duplicate equipment, prosthetics, or supplies
- foot orthoses, except as provided in the Benefit Chart
- services for or related to hearing aids or devices, and related fitting or adjustment, except as specified in the Benefit Chart
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- please refer to the General Exclusions section

Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Office visits from a physical therapist, occupational therapist, speech or language pathologist • Therapies	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you 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.

NOTES:

- **Please see the Notification Requirements section.**
- For lab and diagnostic imaging services billed by a health care professional, refer to Physician Services.
- For hospital/facility charges, refer to Hospital Inpatient and Hospital Outpatient.
- Office visits include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.

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
- 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
- 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 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:	In-Network Providers	Out-of-Network Providers
• Office visit for illness • Office visit for Urgent Care • E-Visit • Office visit at a Retail Health Clinic • Lab and diagnostic imaging • Allergy testing, serum, and injections • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • 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% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon	80% after you pay the deductible.	When you use an Out-of-Network Provider, there is **NO COVERAGE**.

NOTES:

- **Please see the Notification Requirements section.**
- 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- 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 In-Network level 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.
- The Plan covers certain physician services for preventive care. Refer to Preventive Care.
- 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 on-line 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.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- separate charges for pre- 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
- please refer to the General Exclusions section

Prescription Drugs and Insulin

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescription drugs ▪ insulin ▪ prescribed drug therapy supplies ▪ prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for Specialty drugs (see below) ▪ smoking cessation drugs, including over-the-counter nicotine replacement products ▪ amino acid-based elemental formula ▪ prescription prenatal vitamins ▪ prescription pediatric multivitamins with flouride	100% after you pay the applicable member cost-sharing when you present your ID card or otherwise provide notice of coverage at the time of purchase. Refer to Prescription Drugs in the Benefit Chart.	100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. Refer to Prescription Drugs in the Benefit Chart.
• Smoking cessation drugs	100%	100% plus you pay any charges billed to you that exceed the allowed amount but you must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.
• Designated over-the-counter (OTC) drugs with a prescription	100%	No Coverage.
• Designated Specialty drugs purchased through a specialty pharmacy network supplier (see NOTES)	100% after you pay the applicable member cost-sharing. Refer to Prescription Drugs in the Benefit Chart.	No Coverage.

NOTES:

- **Please see the Notification Requirements section.**
- The FlexRx Formulary applies to your Plan. For a list of drugs on your specified formulary, visit the Claims Administrator's website or contact Customer Service.
- 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: growth hormone treatment, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. A current list of designated Specialty prescription drugs and suppliers is available at 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.
- Prescription drugs and diabetic supplies are generally covered in a 31-day supply from a retail pharmacy or up to a 90-day supply from a 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.
- If you choose a brand name drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable member cost-sharing.
- The Plan covers prescription smoking cessation products and over-the-counter (OTC) nicotine replacement products with a physician's prescription subject to your applicable member cost-sharing. Participants in Stop-Smoking Support may use documented enrollment in place of a physician's prescription for the OTC nicotine replacement products. Some quantity limitation may apply.
- The Plan will cover off label drugs used for cancer treatment as specified by law.
- When identical chemical entities including 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.
- 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, refer to Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, refer to Medical Equipment, Prosthetics and Supplies.
- When you pay for your prescription drugs, insulin and drug therapy supplies yourself, you are required to submit the drug receipt(s) with the claim form for reimbursement.
- 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:

- charges for giving injections that can be self-administered
- over-the-counter drugs, except as specified in the 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
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- 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:	In-Network Providers	Out-of-Network Providers
• Professional and outpatient hospital/facility preventive care services include 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 ▪ infants and children ▪ prenatal care	100%	100%

NOTES:

- **Please see the Notification Requirements section.**
- 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 call Customer Service.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USTSPF, ACIP, or HRSA recommendations may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- You are entitled to receive care at the In-Network level for the following services if these services are covered under your Plan: screening for sexually transmitted disease or HIV.

NOT COVERED:

- services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- services for or related to preventive medical evaluations for purposed of medical research, obtaining employment or insurance, or obtaining/maintaining a license of any type
- educational classes or programs, except educational classes or programs required by federal law
- services for or related to lenses, frames, and 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 where eligible under Medical Equipment, Prosthetics, and Supplies
- treatment services or supplies which are investigative or not medically necessary
- please refer to the General Exclusions section

Reconstructive Surgery

The Plan Covers:	In-Network Providers	Out-of-Network 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 to age 18 including dental implants • Elimination or maximum feasible treatment of port wine stains	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- **Please see the Notification Requirements section.**
- Under the Federal Women's Health and Cancer Rights Act of 1998, 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

Skilled Nursing Facility

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

NOTES:

- **Please see the Notification Requirements section.**
- Coverage is limited to a maximum benefit of 120 days per person per calendar year.
- You must be admitted within 14 days after hospital admission of at least three (3) consecutive days for the same illness.
- For take home prescription drugs, 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	Non-Blue Distinction Centers for Transplant (BDCT) 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. See NOTES. 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.	**Participating Transplant Provider** 80% 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. **Nonparticipating Transplant Provider** **NO COVERAGE.** 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.

NOTES:

- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other illness. 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.**

- Travel benefit-Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.
  - The Plan covers the patient up to $50 per day for lodging when purchased at the transplant facility.
  - The Plan covers a companion/caregiver up to $50 per day for lodging.
  - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
  - Total benefit shall not exceed $5,000 per lifetime.
  - Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
  - Reimbursed expenses are not tax deductible. Consult your tax advisor.

NOT COVERED:

- travel benefits when you are using a Non-BDCT Provider
- 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 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 Summary Plan Description
- transplantation of animal organs and/or tissue
- non-covered travel expenses include but are not limited to: meals; utilities; child care; pet care; security deposits; cable hook-up; dry cleaning; laundry; car rental; and personal items
- travel lodging is not eligible when staying with family or friends
- services you receive from a Nonparticipating Provider
- 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 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.

BENEFIT SUBSTITUTION

Benefit substitution, a process of substituting one covered benefit for another covered benefit, is used by the Claims Administrator's care/case managers to facilitate care/case management plans for patients with complex health care needs. The benefit substitution process will be used only when:

1. a care/case management plan is developed in collaboration with the patient and the health care provider prior to the services being provided; and

2. a physician writes an order stating the services to be provided are medically necessary; and

3. the services being provided under the care/case management plan meet the skilled care requirements of the benefit to be used; and

4. the services do not exceed the allowed amount of the benefit being used.

The benefit substitution process cannot be applied retrospectively, and benefit substitution cannot be used to allow coverage for services or supplies excluded by the Plan.

The decision to use the benefit substitution process is a collaborative decision between the Claims Administrator’s care/case managers, the patient or patient’s representative(s), and health care provider. The decision to use the benefit substitution process in a particular case in no way commits the Claims Administrator to do so at another point in the same case or in another case, nor does it prevent the Claims Administrator from strictly applying the express benefits, limitations and exclusions of the Plan at any other time or for any other insured person.

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.
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 pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.
7. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a worker's compensation claim.
8. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's 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 of such a policy.
9. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
10. 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.
11. Services to treat injuries which occur while on military duty that are recognized by the Veterans Administration as services related to service-connected injuries.
12. Treatment of preexisting conditions incurred during the preexisting condition limitation period.
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 *International Classification of Diseases.*
20. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.

21. 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) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.

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

23. 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.

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

25. 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; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

26. 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.

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

28. 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.

29. Services for or related to therapeutic massage.

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

31. Dental implants, and associated services and/or charges, except specified in the Benefit Chart.

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

33. Services for or related to oral surgery and anesthesia for the removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy, except as specified in the Benefit Chart.

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 private-duty nursing, except as specified in the Benefit Chart.

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

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

41. Services and prescription drugs for or related to reproduction treatment including assisted reproductive technology (ART), artificial insemination (AI), and intrauterine insemination (IUI) procedures.

42. 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.

43. Services for or related to reversal of sterilization.

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

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

46. Donor ova or sperm.

47. 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.

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 except 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, and related fitting or adjustment, except as specified in the Benefit Chart.

56. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.

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

58. 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.

59. 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.

60. Services for or related to health clubs and spas.

61. 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.

62. Custodial care.

63. 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.

64. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.

65. Services for or related to the repair of scars and blemishes on skin surfaces.

66. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.

67. 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.

68. 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.

69. 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.

70. Services for or related to gene therapy as a treatment for inherited or acquired disorders.

71. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.

72. Autopsies.

73. Charges for failure to keep scheduled visits.

74. Charges for giving injections that can be self-administered.

75. 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.

76. Services for or related to smoking cessation program fees and/or supplies, except as specified in the Special Features section.

77. Charges for over-the-counter drugs, except as specified in the Benefit Chart.

78. Vitamin or dietary supplements, except as specified in the Benefit Chart

79. Investigative or non-FDA approved drugs, except as required by law.

80. 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.

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

82. 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 support procedures that are considered investigative or not medically necessary.

83. Services for or related to fetal tissue transplantation.

Eligible Employees

To be eligible for coverage you must maintain, on a consistent weekly basis, the full time hours required by your specific job title/position or an employee that is out on a company approved leave of absence.

- **New Hires** – Coverage will be effective on the first of the month following or coinciding with 90 days from the date of hire
- **Rehires** – Coverage will be effective on the first of the month following or coinciding with 90 days from the date of hire.
- **Part-time to Full-time** – If an employee moves from a part-time position to a full-time position, the employee will be eligible for benefits on the first of the month following a waiting period of whichever is lesser, either: 1.) 180 days of continuous employment (part-time and full-time combined) or 2.) Following 90 days of full-time employment.
- **Full-time to Part-time to Full-time** – Not having met any eligibility waiting period: If an employee is full-time and becomes part-time, COBRA benefits will be offered. If the employee then becomes full-time again, the employee must have had continuous employment and meet the lesser of the 90 day (as full-time) or 180 day (part-time and full-time combined) waiting period from original date of hire.

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: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Spouse

1. Spouse, meaning:

    a. Legally married opposite gender 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 have legal guardianship and who live with you continuously from birth and are financially dependent upon you.

6. Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a). 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. 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.

Preexisting Condition Limitation for Late Entrants – Age 19 and Older

A preexisting condition limitation applies to late entrants 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.

For such a condition, benefits for you and your covered dependents will be payable only after a period of 18 consecutive months beginning from the enrollment date. This period will be reduced by any prior continuous qualifying creditable coverage, provided no gap in coverage greater than 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 on the first of the month following or coinciding with the date of eligibility.

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 an eligible employee or dependent 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; or 4.) acquiring a new dependent. The request for enrollment must be within 30 days (unless otherwise noted) of the eligible circumstances.

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 Plan may enroll for coverage in the Plan as special enrollees upon the 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 the premium or for cause), he/she is no longer eligible for the Plan due to legal separation, 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 requested 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 is effective the day after the termination of prior coverage or the date of 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

Employee's or dependents who are eligible but not enrolled in this Plan may enroll for coverage under this Plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

a. the employee or dependent was covered under Medicaid or CHIP 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, Medicaid or CHIP coverage was the reason for declining enrollment; and

c. the employee 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 this Plan, may enroll for coverage under this 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 employee 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 under this Plan may enroll themselves and newly acquired dependents for coverage under this Plan as special enrollees. If the employee is eligible under the terms of the Plan, the employee and eligible dependent are eligible for special enrollment when the employee acquires a new dependent through marriage, birth, adoption or placement for adoption.

Coverage is effective on the date of marriage, birth, adoption or placement for adoption, if application is received within 30 days after the marriage, birth, adoption or placement for adoption.

Dependent children other than the newly acquired dependent are not eligible for the special enrollment period.

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 than 63 days has occurred. Coverage for late entrants starts on the first of the month following the day the Plan Administrator receives the application.

TERMINATION OF COVERAGE

Termination Events

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, the date on which:

    a. required charges for coverage were paid, if payment is not received when due. Your payment of charges 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 charges, 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.

    e. you retire.

3. For the spouse, the date the spouse is no longer eligible for coverage. This is the date on which 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 date on 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 as an employee under any health coverage plan sponsored by any employer. Contact the Plan Administrator to determine if applicable to our plan.

    d. the disabled dependent is no longer eligible.

    e. the dependent grandchild is no longer eligible.

5. The date charges are incurred that result in payment up to the lifetime maximum.

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 certificate 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).

If you are the **ex-spouse/*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 divorceor legal separation.)
- The ***employee*** becomes enrolled in Medicare.

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.
- Parents’ divorce or legally separate.
- The ***employee*** becomes enrolled in Medicare.
- The dependent ceases to be a “dependent child” under the Plan.

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 legal separation.
- 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 actually terminates.

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

When you notify the employer of a divorce, 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 may waive your right to continuation coverage during the 60-day election period. If you do so, you may later revoke your waiver during the same 60-day election period. Revoking your waiver will result in continuation coverage beginning on the day after the plan administrator receives your revocation.

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, an ex-spouse/spouse may not decline coverage for the other ex-spouse/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 of the ***employee's*** death, divorce, legal separation, the ***employee*** became enrolled in Medicare or because of a loss of dependent status under the Plan, then the maximum coverage period (for spouse/ex-spouse and dependent child) is three (3) years from the date of the qualifying event.

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 percent of the group rate for months 19-29 if the disable dependent is covered. If the qualifying event for continuation is the ***employee's*** total 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 you or 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 maximum coverage period (i.e., death of the ***employee,*** divorce, legal separation, the ***employee*** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the ***employee's*** dependents who are qualified beneficiaries.

  When a second qualifying event that gives rise to a 36-month maximum coverage period for the dependent, 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, 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.

- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

- 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.

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 you or your dependent's address changes, you must notify the Plan Administrator in writing so the Plan Administrator may mail you or your dependents 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 percent 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 identification card for assistance.

Overview

The following chart is an overview of the information outlined in the previous sections. For more details, 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 (layoff, 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 legal separation	Ex-spouse/spouse and any dependent children who lose coverage	Earliest of: **1.** 36 months; or **2.** Enrollment date in other group coverage; or **3.** Date coverage would otherwise end.
• Death of employee	Surviving spouse and dependent children	Earliest of: **1.** 36 months; or **2.** Enrollment date in other group coverage; or **3.** 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 Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: • Disability, as determined by the Social Security Administration, of employee or dependent(s)	Disabled individual and all other covered family members	Earliest of: **1.** 29 months after the employee leaves employment; or **2.** Date 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/ IPT coverage and charges will not be the same as this 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. The term “plan” means 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 required or provided by law; and

    c. individual coverage.

    d. the medical payment (“medpay”) or personal injury protection benefit available to you under an automobile insurance policy.

    Therefore, “plan” does not include:

    a. 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); or

    b. any benefits that, by law, are excess to any private or other nongovernmental program.

    If any of the above coverages include group-type hospital indemnity coverage, “This Plan” only includes that amount of indemnity benefits which exceeds $100 a day.

2. The term “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 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 three (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. The plan that covers a person as automobile insurance medical payment (“medpay”) or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.

   b. 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.

   c. 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.

   d. 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;

      3) finally, the plan that covers the parent not having physical custody of the child; or

      4) in the case of joint physical custody, b. above applies.

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.

e. 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.

f. 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 a 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

This Plan maintains both a right of reimbursement and a separate right of subrogation. **As an express condition of your participation in this Plan, you agree that the Plan has the subrogation rights and reimbursement rights explained below.**

The Plan's Right of Subrogation

If you or your dependents receive benefits under this Plan arising out of an illness or injury for which a responsible party is or may be liable, this Plan shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to Reimburse the Plan

You are obligated to reimburse the Plan in accordance with this provision if the Plan pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the Plan for 100 percent of benefits paid by the Plan before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the Plan from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The Plan is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the Plan; and/or
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Plan.

Until the Plan has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the Plan is related shall be held by the recipient in constructive trust for the satisfaction of the Plan's subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the Plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action – including, but not limited to, settlement of any claim – that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the Plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the Plan by providing written notification to the Claims Administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the Plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or

2. bring a legal action against any other party.

You have a continuing obligation to notify the Claims Administrator of information about your efforts or your dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement,** as required by the Plan and provide any other information required by the Plan. A violation of the reimbursement agreement is considered a violation of the terms of the Plan.

The Plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Plan may require you to assign your rights of recovery to the extent of benefits provided under the Plan. The Plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this Plan. The Plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the Plan may elect.

Attorneys' Fees and Other Expenses You Incur

The Plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the Plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the Plan's right to reimbursement without the express written consent of the Claims Administrator.

The Plan Administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the Claims Administrator.

What May Happen to Your Future Benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the Plan, the Plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the Plan's subrogation and reimbursement efforts. If the Plan determines that you have failed to cooperate the Plan may decline to pay for any additional care or treatment for you or your dependent(s) until the Plan is reimbursed in accordance with the Plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the Plan for you and your dependents.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

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 or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the Board of Directors. 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 by the employer 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, including ERISA, 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:

- Benefits Administrator
- Human Resource Operations Manager
- Human Resource Systems

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.

Employee Retirement Income Security Act (ERISA) Statement of Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

a. Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

a. Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.

b. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you should disagree with the Plan's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the fiduciaries misuse the Plan's

money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Important Plan Information

Plan Name:	Christensen Farms & Feedlots, Inc Preferred Provider Organization (PPO) Health Care Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
Plan Year:	January 1 through December 31
Plan Number:	501
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution 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.
Type of Plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the Plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor:	Christensen Farms & Feedlots, Inc. 23971 County Road 10 P.O. Box 3000 Sleepy Eye, MN 56085 (507) 794-5310
Plan Sponsor's Employer Identification Number:	41-1688501
Plan Administrator:	Christensen Farms & Feedlots, Inc. 23971 County Road 10 P.O. Box 3000 Sleepy Eye, MN 56085 (507) 794-5310
Named Fiduciary for Claims Purposes:	BCBSM
Named Fiduciary for all other Purposes:	Christensen Farms & Feedlots, Inc. 23971 County Road 10 P.O. Box 3000 Sleepy Eye, MN 56085 (507) 794-5310

Agent for Services of Legal Process:	Benefits Administrator Christensen Farms & Feedlots, Inc. 23971 County Road 10 P.O. Box 3000 Sleepy Eye, MN 56085 (507) 794-5310 Service of legal process may also be made on the Plan Administrator.
Plan Document:	The Plan and its attachments, if any, constitute the written plan document required by ERISA §402.

GLOSSARY OF COMMON TERMS

Refer to the Benefit Chart for specific benefit and payment information.

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 payment is based for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the Benefit Chart.

The Allowed Amount for Participating Providers

For Participating Providers, the allowed amount is the negotiated amount of payment that the Participating 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 Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating 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, rebates, and other methods, the Claims Administrator may subsequently adjust the amount due to Participating Providers. These subsequent adjustments will not impact or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Claims Administrator or the contract-holder, and the percentage of the allowed amount paid by the Claims Administrator is lower than the stated percentage for the covered service (and the percentage paid by you is higher). If the payment to the provider is increased, the Claims Administrator pays that cost on your behalf, and the percentage of the allowed amount paid by the Claims Administrator is higher than the stated percentage and the percentage paid by you is lower.

The Allowed Amount for Nonparticipating Providers

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this amount is intended to represent a usual, customary or reasonable charge. 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, certain procedures billed by a Nonparticipating Provider may be combined into a single procedure or denied as not a covered service for purposes of determining what the designated percentage will be applied

against.

The Allowed Amount for Nonparticipating Provider Professional Services (physicians or clinics) in Minnesota

For physician or clinic services by Nonparticipating Providers in Minnesota, except those described under Special Circumstances below, the allowed amount is most commonly the amount in the Nonparticipating Provider Professional Services in Minnesota Fee Schedule. You may view this fee schedule at the Claims Administrator's website. You may also call Customer Service to obtain a copy of the portions of the fee schedule which are relevant to you. These proprietary fee schedules are for the information of the Claims Administrator's members only and are not to be used for any other purpose. They are subject to change without notice. You may need to talk with your Nonparticipating Provider to determine what procedure codes are applicable to the services your Nonparticipating Provider will provide in order to determine which parts of the fee schedule apply.

The allowed amount is the lesser of: (1) the Nonparticipating Provider Professional Services in Minnesota Fee Schedule: or. (2) a designated percentage of the Nonparticipating Provider's billed charges. No fee schedule amounts include any applicable tax.

The fee schedule that is current as of the time the services are provided will be the fee schedule that is used for determining the allowed amount.

Your Plan may employ another methodology (other than noted above) for determining the allowed amount by using a specified percentile in a medical fee database for the service provided.

The Allowed Amount for all other Nonparticipating Providers (facility services) in Minnesota

The Claims Administrator's allowed amount for Nonparticipating Provider facility services is a designated percentage of the facility's billed charges, except those described under Special Circumstances below, and is subject to business rules established in the Claims Administrator's Provider Policy and Procedure Manual. Examples of facility-based provider types include, but are not limited to hospitals, skilled nursing facilities or renal dialysis centers.

The Allowed Amount for Nonparticipating Provider Professional Services (physicians or clinics) outside Minnesota

For Nonparticipating Provider physician or clinic services outside of Minnesota, except those described under Special Circumstances below, the allowed amount is most commonly determined by the local Blue Cross and/or Blue Shield Plan, unless that amount is greater than the Nonparticipating Provider's billed charge, or no allowed amount is provided by the local Blue Plan. In that case, the allowed amount will be based on a percentage of pricing obtained from a nationwide provider reimbursement database that considers various factors, including the ZIP code of the place of service and the type of service provided. If this database pricing is not available for the service provided, the Claims Administrator will use the allowed amount for Nonparticipating Providers in Minnesota.

Your Plan may employ another methodology (other than noted above) for determining the allowed amount by using a specified percentile in a medical fee database for the service provided.

The Allowed Amount for all other Nonparticipating Providers (facility services) outside Minnesota

For Nonparticipating Provider facility services outside of Minnesota, except those described under Special Circumstances below, the allowed amount is determined by the local Blue Cross and/or Blue Shield Plan, unless that amount is greater than the Nonparticipating Provider's billed charge, or no allowed amount is provided by the local Blue Plan. In that case, the allowed amount is determined from a Medicare-based fee schedule. If such pricing is not available, payment will be based on a percentage of the Nonparticipating Provider's billed charges.

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 insemination (IUI), or artificial insemination (AI)), 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.

BlueCard Network Provider

Providers who have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan outside of Minnesota.

BlueCard Program

A national Blue Cross and Blue Shield program in which employees and dependents can receive health plan benefits while traveling or living outside the state of Minnesota. Employees and dependents must show their membership ID to secure benefits.

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 a care/case manager 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.

Claims Administrator

Blue Cross and Blue Shield of Minnesota (Blue Cross)

Coinsurance

The percentage of the allowed 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 Participating Providers, coinsurance is calculated based on the lesser of the allowed amount or the Participating Provider's billed charge. Because payment amounts are negotiated with Participating Providers to achieve overall lower costs, the allowed amount for Participating 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 Participating Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage.

For covered services from Out-of-Network 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 an Out-of-Network Provider is used. For example, if an Out-of-Network 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 Participating 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 Out-of-Network 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 are 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 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 or 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.

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, 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).

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.
Formulary	The Claims Administrator's formulary 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 formulary unless they are specifically listed.
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.
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.

In-Network Provider

A provider that has entered into a specific network contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan. Refer to the Benefit Chart and Coverage Information sections for network details.

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.

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.

Intermediate maximum

The point where the Plan starts to pay 100% for certain covered services for the rest of the applicable plan or calendar year. Your allowed amounts must total the intermediate maximum.

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.

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 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, penalties, 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.

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 addictions.
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.
Opioid treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Network Provider	A Participating Provider that is not In-Network; and Nonparticipating Providers.

Out-of-pocket maximum	The most each person must pay each applicable plan or calendar 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 applicable plan or calendar year. The Benefit Chart lists the out-of-pocket maximum amounts.
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 who 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.
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 beginning on your coverage enrollment date during which services related to preexisting conditions will not be covered services under the Plan. This limitation does not apply to covered members less than 19 years of age.

Prescription drug deductible	A separate deductible amount that must be satisfied prior to any benefit for prescription drugs. The amount of this deductible is shown in the Benefit Chart.
Prescription drug out-of-pocket maximum	The most you must pay toward the allowed amount for prescription drugs per applicable plan or calendar year. After you reach the prescription drug out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for the rest of the applicable plan or calendar 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.
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.
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.

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.
Services	Health care service, 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 non-medical 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: 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, but is not limited to 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.

Supervised employees

Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities 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 percent 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. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; or
6. 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 communications permitting real-time communications 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 and 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 the health plan.