Y O U R H E A L T H C A R E

CERTIFICATE

CARLETON COLLEGE ATTN:HUMAN RESOURCES

BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

SAMPLE, SAMPLE X
ADDRESS
ADDRESS
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ADDRESS

Group Number: XXXXX-XX XXX
Identification Number: ON FILE
Type of Coverage: SINGLE

BENEFIT SUMMARY

Blue Cross and Blue Shield of Minnesota

CARLETON COLLEGE ATTN:HUMAN RESOURCES

BENEFITS EFFECTIVE: 01-01-2011
POLICY YEAR AND RENEWAL DATE:
FORM: X8776-R19 Date Run: 01-25-11

Options Blue Health Reimbursement Account (HRA) Group Certificate

Networks: • In-Network Providers § Minnesota § Outside Minnesota	 Aware Network Providers BlueCard Traditional Network Providers
Covered Percentage: • In-Network Providers • Out-of-Network Providers	 Generally, 80% of the Allowed Amount after you pay the deductible, up to the out-of-pocket maximum, 100% thereafter to the end of the calendar year. Generally, 80% of the Allowed Amount after you pay the deductible, up to the out-of-pocket maximum, 100% thereafter to the end of the calendar year.
Deductible: • All Providers combined Deductible carryover applies (The amount applied toward your deductible, under this Plan, during the last three (3) months of the calendar year that we apply toward your deductible, under this Plan, for the next calendar year. This amount will not be applied toward the out-of-pocket maximum for the next calendar year.)	 $1,000 per person per calendar year
Prescription Drugs • **Generic Drugs** § Retail Pharmacy § 90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	 $15 copay $30 copay
• **FlexRx Formulary Brand Name Drugs** § Retail Pharmacy § 90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	 $35 copay $70 copay

This Benefit Summary is subject to change in accordance with the terms of your certificate. Coverage is subject to all terms, conditions, and definitions of the certificate.

• **Nonformulary Brand Name Drugs** § Retail Pharmacy § 90dayRx: • Participating Retail 90dayRx Pharmacy • Mail Service Pharmacy	 $55 copay $110 copay
Out-of-Pocket Maximum: • Prescription drug costs, other than costs for drugs dispensed and used during inpatient admission, including prescription copays and/or prescription drug deductibles • All other eligible services all providers combined § The following are included in the Out-of-Pocket Maximum: • deductibles • copays • coinsurance § The following are NOT included in the Out-of-Pocket Maximum: • applicable prescription drug cost-sharing • deductible carryover The price difference between brand name and generic drugs does not apply toward the out-of-pocket maximum.	 $750 per person per calendar year $1,900 per person per calendar year
Lifetime Maximum: • Reproduction Treatments § All services combined (medical and prescription drugs) • Total benefits paid to all providers combined	 $10,000 per person Unlimited per person

Dependents

Dependent children, when added to the Plan, are covered up to age 26. Disabled dependents are covered up to the age limits specified in the "Eligibility" section.

All coverage for dependents and all references to dependents in this certificate are inapplicable for group member-only coverage.

Preexisting Condition Limitation Period - Age 19 and Over

The time period beginning on your coverage enrollment date during which services related to preexisting conditions will not be covered under this health benefit plan. Late entrants will be subject to an 18-month preexisting condition limitation period. We will credit the time period that you have maintained continuous qualifying creditable coverage without a gap in coverage greater than 63 days against the 18-month period to reduce your specific preexisting condition limitation period. At your request, and with appropriate authorization, we will assist you in obtaining a certificate of qualifying 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.

The following dependents are not subject to a preexisting condition exclusion:

1. disabled dependents;
2. newborns added effective as of the date of birth;
3. newly adopted dependents added as of the date of adoption or placement for adoption; and
4. covered persons under 19 years of age.

If you have questions regarding the Preexisting Condition Limitation Period provision, please contact us at the address or telephone number listed in the "Customer Service" section or refer to your Identification (ID) card.

BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

OPTIONS BLUE HEALTH REIMBURSEMENT ACCOUNT (HRA) GROUP CERTIFICATE

THIS HEALTH CARE PLAN IS INTENDED FOR USE WITH A FINANCIAL ACCOUNT

THIS IS A MINNESOTA
PLEASE READ YOUR CERTIFICATE CAREFULLY

Because of our concern for the environment, this document is entirely recyclable as business office paper.
When you no longer need it, recycle if possible.

ANNUAL NOTIFICATIONS

General Provider Payment Methods

Participating Providers

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

Several methods are used to pay participating 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%) 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"). This 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 we determine by comparing market prices (for generic drugs only); or
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with a Blue Cross 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 Blue Cross 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, Blue Cross 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 example below.

	Participating Provider	**Nonparticipating Provider**
Provider Charge:	$150	$150
Allowed Amount:	$100	$60
Blue Cross 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*

*Blue Cross 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 Blue Cross.

- **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, Blue Cross 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 our 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 on our website at www.bluecrossmn.com.

Women's Health and Cancer Rights Act

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

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses 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.

Disclosure of Grandfather Status

The Plan believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

The group contractholder is required to notify Blue Cross of the contribution rate in effect on March 23, 2010, the contribution rate in effect upon each renewal, and must notify us promptly if the contribution rate changes at any point during the plan year.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the group contractholder.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Important Notice From Blue Cross and Blue Shield of Minnesota About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Cross and Blue Shield of Minnesota (Blue Cross) and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. **Blue Cross has determined that the prescription drug coverage offered by your Plan is, on average for all members, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore considered Creditable Coverage. Because your 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 Blue Cross coverage will not be affected. You may keep your current Blue Cross coverage and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop Blue Cross 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 with Blue Cross and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

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

- Visit www.medicare.gov
- Call Customer Service at 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 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).

Blue Cross and Blue Shield of Minnesota Member Rights and Responsibilities

You have the right as a health plan member 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 Blue Cross and its health care providers in accordance with existing law;
- receive information about Blue Cross, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at Blue Cross or at the clinic that you can contact with any concerns about services;
- file a complaint with Blue Cross and the Minnesota Commissioner of Commerce and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with Blue Cross or its providers.

You have the responsibility as a health plan member to:

- know your health plan benefits and requirements;
- provide, to the extent possible, information that Blue Cross 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 certificate is issued and delivered in the state of Minnesota, is subject to the laws of the state of Minnesota, and is not subject to the laws of any other state.

This certificate describes your Blue Cross and Blue Shield of Minnesota (Blue Cross) health care coverage. It replaces all other certificates you have received from us before the effective date specified in the "Benefit Summary." For purposes of this certificate, "you" or "your" refers to the group member named on the identification (ID) card and other covered dependents. Group member is the person for whom the group contractholder has provided coverage. Dependent is a covered dependent of the group member. The group contractholder has contracted with us to provide coverage for its group members and their dependents. "We," "us," and "our" refer to Blue Cross. Other terms are defined in the "Definitions" section.

This certificate explains the Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. It is important that you read this entire certificate carefully. If you have questions about your coverage, please contact us at the address or telephone numbers listed on the "Customer Service" page.

Blue Cross is the insurer and the claims administrator. This Plan is a fully-insured medical plan. Coverage is subject to all terms and conditions of this certificate, including medical necessity.

The 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 us or the local Blue Cross and/or Blue Shield Plan to provide you quality health services at favorable prices.

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 have entered into a specific network contract with us or the local Blue Cross and/or Blue Shield Plan but are not In-Network Providers. Nonparticipating Providers have not entered into a network contract with us or the local Blue Cross and/or Blue Shield Plan. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

Coverage under this Plan for eligible group members and dependents will begin as specified in the "Benefit Summary" or in the "Eligibility" section.

All coverage for dependents and all references to dependents in this certificate are inapplicable for group member-only coverage.

IMPORTANT! We issue each group member and dependent an Identification (ID) card. If any of the information on your ID card is not correct, please contact us immediately. When receiving care, present your ID card to the provider who is rendering the services.

CUSTOMER SERVICE

Questions?	Our customer service staff is available to answer questions about your coverage and direct your calls for preadmission and emergency admission notification. Monday through Thursday: 7:00 AM – 7:00 PM Central Time Friday: 9:00 AM – 6:00 PM Central Time *Hours are subject to change without prior notice.*
Customer Service Telephone Number	(651) 662-5004 or toll-free 1-866-870-0348
Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmn.com
BlueCard Telephone Number	Toll-free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield Plans nationwide.
BlueCard Website	www.bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield Plans nationwide.
Mailing Address	Claims review requests and 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
Office Address	You may visit our Home Office during normal business hours: Blue Cross and Blue Shield of Minnesota RiverPark II 1800 Yankee Doodle Rd. Eagan, MN 55122
Pharmacy Telephone Number	Toll-free 1-800-509-0545 This number is used to locate a Participating Pharmacy.

A copy of our privacy procedures is available on our website at www.bluecrossmn.com or by calling Customer Service at the telephone number listed above.

DISTRICT OFFICES

MINNEAPOLIS/ST. PAUL

RiverPark II
1800 Yankee Doodle Rd.
Eagan, MN 55122

1-800-382-2000 (NATL)
1-651-662-8000
1-651-662-1657 (FAX)
1-651-662-8700 (TDD/TTY)

DULUTH

21 W. Superior Street, Suite 110
Duluth, MN 55802

1-800-232-1383 (NATL)
1-218-722-3371
1-218-722-3830 (FAX)

COVERAGE INFORMATION

Choosing a Health Care Provider

You may choose any eligible provider of health services for the care you need. We 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.

We feature a large network of Participating Providers, and each provider is an independent contractor and is not our agent.

In-Network Providers

When you choose In-Network Providers, you get the most benefits for the least expense and paperwork. Minnesota In-Network Providers are providers in the Aware Network. In-Network Providers outside Minnesota are providers in the BlueCard Traditional Network. Minnesota In-Network Providers are required to take care of notification requirements and send your claims to us and we send payment to the provider for covered services you receive. In-Network Providers outside Minnesota are required to send your claims to us and we send payment to the provider for covered services you receive. In-Network Providers outside Minnesota are not required to take care of notification requirements. 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 a 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 us 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 perform for you. Most out-of-state Out-of-Network Participating Providers accept our payment based on the Allowed Amount. We recommend that you contact the out-of-state Out-of-Network Participating Provider and verify if they accept our 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 us 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 receiving care from In-Network Providers. In addition, participating facilities may have nonparticipating professionals practicing at the facility.

Your Benefits

This certificate outlines the coverage under this Plan. Please be certain to check the "Benefit Summary" section to identify covered benefits. You must also refer to the "General Exclusions" section to determine if services are not covered. The "Definitions" section defines terms used in this contract. 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 at the telephone number on the back of your ID card.

Your Monthly Premiums

We charge your employer a monthly rate (premium). We may revise this rate during the plan year due to changes in the group's status.

Monthly rates are based on each individual's age and may be adjusted upon annual renewal and when a person reaches a birthday ending in a five or a zero. For example, premium rates increase when a member reaches age 30, 35, 40, 45, etc.

Monthly rates for a covered dependent child remain the same until the child loses eligibility and takes continuation coverage. Monthly rates for a former dependent child are the same as those for an adult of the same age.

Your monthly contribution amount (if any) is determined by your employer.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to Blue Cross, this section applies to you. If you are currently receiving care from an Out-of-Network family practice or specialty physician, 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 us. We 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. We 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 (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) 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 speaks 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

Blue Cross will assist you in making the transition from an Out-of-Network to an In-Network Provider if you request us to do so. Please contact Customer Service 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 Blue Cross' Allowed Amount; 2) adhere to all Blue Cross' prior authorization requirements; and 3) provide Blue Cross with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with Blue Cross, we 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 we have terminated our relationship with your provider for cause, we 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 with Blue Cross, this section applies to you. If the relationship between your In-Network clinic or physician and Blue Cross ends, rendering your clinic or provider Out-of-Network with us, and the termination was by Blue Cross and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an In-Network Provider as required under the terms of your coverage with us. We 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. We 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 (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) 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 speaks 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

Blue Cross will assist you in making the transition from an Out-of-Network to an In-Network Provider if you request us to do so. Please contact Customer Service 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 Blue Cross' Allowed Amount; 2) adhere to all Blue Cross' prior authorization requirements; and 3) provide Blue Cross with necessary medical information related to your care.

Termination by Provider

If your provider terminates its contract with Blue Cross, we 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 we have terminated our relationship with your provider for cause, we 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.

Payments Made in Error

Payments made in error or overpayments may be recovered by Blue Cross as provided by law. Payment made for a specific service or erroneous payment shall not make Blue Cross or the group contractholder 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 and coinsurance;
2. copays;
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 based on the Allowed Amount. You may not be required to pay for charges that exceed the Allowed Amount. All Out-of-Network Participating Providers in Minnesota accept our payment based on the Allowed Amount. Most Out-of-Network Participating Providers outside Minnesota also accept our payment based on the Allowed Amount. However, contact your Out-of-Network Participating Provider outside Minnesota to verify if they accept our payment based on the Allowed Amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the Allowed Amount if the Out-of-Network Participating Provider outside Minnesota does not accept our payment based on the Allowed Amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

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 us 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 and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered, including services that we determine are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary.

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

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

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

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

Nonparticipating Providers Outside Blue Cross' Service Area

1. Member Liability Calculation

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

2. Exceptions

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

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 "Definitions" section.

Fraudulent Practices

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

Excessive and Harmful use of Health Care Services

Blue Cross monitors claims data for many reasons. When Blue Cross determines that you are receiving an excessive number of health care services and/or an excessive number of prescription drugs, Blue Cross evaluates such services. When Blue Cross determines that an excessive number of services or prescription drugs are not necessary, the following will occur:

- Blue Cross will send you a letter giving you 30 days to select one (1) participating physician, and one (1) participating hospital, and one (1) participating pharmacy to coordinate all of your health care needs. If you do not make a selection, then Blue Cross will select one (1) for you. Once the selection is made, all services must be coordinated by the selected providers. Care received from other providers will not be covered and the charges will be your responsibility.
- Blue Cross will notify you how to obtain care not available through the coordinating health care providers, how to access emergency care, and how long these restrictions will be in place.

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

Our 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

Blue Cross 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. 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.** We require that you or the provider contact us at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. We will notify you of our 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 Blue Cross medical policy. The most current list is available on our website at www.bluecrossmn.com or by calling Customer Service.

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

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

***Blue Cross reserves the right to revise, update, and/or add to this list at any time without notice. The current list is available on our website at www.bluecrossmn.com or by calling Customer Service.**

We prefer that all requests for prior authorization be submitted to us in writing to ensure accuracy. Please refer to the "Customer Service" section for the telephone number and appropriate mailing address for prior authorization requests.

Preadmission Notification

Preadmission notification is a process whereby the provider, or you, inform us that you will be admitted for inpatient hospitalization services. 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 notification for you.

If you are going to receive nonemergency care from In-Network Providers outside Minnesota or Out-of-Network Providers, you are required to provide preadmission notification to us. 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. Please refer to "Prior Authorization" in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

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

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

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or services. Preadmission certification includes 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 or Out-of-Network Providers, you are required to provide preadmission certification to us. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Please refer to "Prior Authorization" in this section. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

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

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

Emergency Admission Notification

In order to avoid liability for charges that are not considered medically necessary, you are required to provide emergency admission notification to us 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 or Out-of-Network Providers, you are required to provide emergency admission notification to us. 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.

BENEFIT CHART

This section lists covered services and the benefits we pay. All benefit payments are based on the Allowed Amount. Coverage is subject to all other terms and conditions of this certificate and must be medically necessary.

Benefit Descriptions

Please 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 medical facility equipped to treat the condition • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	80% after you pay the deductible.	

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	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 when you use a Non-Blue Distinction Participating Provider. When you use a Nonparticipating Provider there is **NO COVERAGE.**
• Medically necessary **outpatient hospital/facility** services for bariatric surgery: § Scheduled bariatric surgery/anesthesia § Lab and diagnostic imaging § All other eligible outpatient hospital care related to the scheduled bariatric surgery provided on the day of surgery	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 when you use a Non-Blue Distinction Participating Provider. 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, please refer to "Physician Services."**
- Blue Distinction Centers for Bariatric surgery are designated facilities within participating Blue Plan's 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. All requests for prior authorization must 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 contact Customer Service or visit our website at www.bluecrossmn.com.
- For pre- and post-operative bariatric services please refer to "Hospital Inpatient," "Hospital Outpatient," "Physicians Services," etc.

NOT COVERED:

- services you receive from a Nonparticipating Provider

BARIATRIC SURGERY (continued)

NOT COVERED:

- 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	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.
• Outpatient hospital/outpatient behavioral health treatment facility charges for services including: § evaluation and diagnostic services § individual/group therapy § crisis evaluations § observation beds § family therapy	80% after you pay the deductible.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Professional health care charges for services including: § clinical based partial programs § clinical based day treatment § clinical based Intensive Outpatient Programs (IOP)	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.
• Facility health care charges for services including: § hospital based partial programs § hospital based day treatment § hospital based Intensive Outpatient Programs (IOP)	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.
• Inpatient health care professional charges	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.
• Inpatient hospital/inpatient behavioral health treatment facility charges for services including: § all eligible inpatient services § emergency holds	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.
• Residential behavioral health treatment facility charges	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.**
- 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.

BEHAVIORAL HEALTH MENTAL HEALTH CARE (continued)

NOTES:

- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by us. 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.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- 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 treatment of emotionally disabled children in a licensed residential behavioral health treatment facility.
- For lab and diagnostic imaging services billed by a health care professional, please refer to "Physician Services." For lab and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."
- For home health related services, please refer to "Home Health Care."
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone consultations, except for eligible E-Visits.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- 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.

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
- evaluations that are not performed for the purpose of diagnosing or treating mental health disorders including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
- room and board for foster care, group homes, shelter care, and lodging programs
- halfway house services
- services for 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
- services for marriage/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder
- 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	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.
• Outpatient hospital/outpatient behavioral health treatment facility charges for services including: § Intensive Outpatient Programs (IOP) and related aftercare services	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.
• Inpatient health care professional charges	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.
• Inpatient hospital/residential behavioral health treatment facility charges	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.**
- 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 us. 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 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.
- For lab and diagnostic imaging services billed by a health care professional, please refer to "Physician Services." For lab and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."
- For home health related services, please refer to "Home Health Care."
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone consultations, except for eligible E-Visits.
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."

NOT COVERED:

- services for substance abuse or addictions that are not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants

BEHAVIORAL HEALTH SUBSTANCE ABUSE CARE (continued)

NOT COVERED:

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

CHIROPRACTIC CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Office visits from a doctor of chiropractic • Manipulations	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.
• Therapies • Other chiropractic services	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.**
- Office visits include medical history; medical examination; medical decision making; counseling; coordination of care; nature of presenting problem; and chiropractor's time.
- For lab and diagnostic imaging services billed by a health care professional, please refer to "Physician Services." For lab and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."

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); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc., and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable 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 when services are scheduled or initiated prior to the member turning age 19 including: § dental implants § removal of impacted teeth or tooth extractions § related orthodontia § related oral surgery § bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: § orthognathic surgery § related orthodontia	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.**
- 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 please refer to "Hospital Inpatient" or "Hospital Outpatient."
- For medical services please refer to "Hospital Inpatient," "Hospital Outpatient," "Physician Services," etc.
- Services for surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) 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 (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.

NOT COVERED:

- all orthodontia, except as specified in the "Benefit Chart"
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts

NOT COVERED:

- dental implants, 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 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"
- services for or related to oral surgery and anesthesia for removal of impacted teeth, a tooth root without removal of the whole tooth, and 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 CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional charges	80% after you pay the deductible.	
• Outpatient hospital/facility charges	80% after you pay the deductible.	

NOTES:

- **Please see the "Notification Requirements" section.**
- When determining if a situation is a medical emergency we will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, please refer to "Hospital Inpatient" and "Physician Services."
- For urgent care visits, please refer to "Hospital Outpatient" and "Physician Services."

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 § 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.	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.**
- Benefits for home infusion therapy and related home health care are listed under "Home Infusion Therapy."
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to "Medical Equipment, Prosthetics, and Supplies."
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- services for or related to private-duty nursing, except as required by Minnesota law
- 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 the home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	80% after you pay the deductible.	**NO COVERAGE**.

NOTE:

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

NOT COVERED:

- services you receive from an Out-of-Network Provider
- 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.	**NO COVERAGE.**

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 patients with a terminal condition (i.e., life expectancy of six (6) months or less). The patient's primary physician must certify, in writing, a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

- services you receive from an Out-of-Network Provider
- room and board expenses in a 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 • Diagnostic imaging • Communication services of a private duty nurse or personal care assistant up to 120 hours per hospital admission	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.**
- 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 hospital/facility charges for bariatric surgery, please refer to "Bariatric Surgery."

NOT COVERED:

- 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
- communication services provided on an outpatient basis or in the home
- services for or related to private-duty nursing, except as required by Minnesota law
- 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 • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • All other eligible outpatient hospital care	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.
• Urgent care	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.
• Lab	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.
• Diagnostic imaging	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.**
- The Plan covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the patient's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- For hospital/facility charges for bariatric surgery, please refer to "Bariatric Surgery."

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	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.
• Hospital/facility services for delivery and postpartum care	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.**
- For prenatal care benefits, please refer to "Preventive Care."
- Please refer to the "Eligibility" section to determine when the newborn's coverage will begin if the newborn is added to the Plan.
- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
  - § Inpatient hospital coverage for the **mother**, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
  - § Inpatient hospital coverage for the **newborn**, if added to the certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
- Under federal law, the Plan may require that a provider obtain authorization from the Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.

NOT COVERED:

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

MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES

The Plan Covers:	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, surgical stockings, casts, and dressings • Insulin pumps, glucometers, and related equipment and devices • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years. • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp hair prosthesis (wigs) provided hair loss is due to alopecia areata. Maximum of $350 per person per calendar year. Deductible does not apply. • Custom foot orthoses if you have a diagnosis of diabetes with neurological manifestations of one 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. The exception to this requirement is oxygen-aiding equipment which requires continuous maintenance.
- 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."
- For hearing aid exam services, please refer to "Physician Services."

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and except as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary

MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES (continued)

NOT COVERED:

- 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
- 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, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Benefit Chart"
- duplicate equipment, prosthetics, or supplies
- foot orthoses, except as specified in the "Benefit Chart"
- services for or related to hearing aids or devices, except as specified in the "Benefit Chart"
- nonprescription supplies, such as alcohol, cotton balls and alcohol swabs
- please refer to the "General Exclusions" section

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Office visits from a physical therapist, occupational therapist, speech or language pathologist	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.
• Therapies • Office visits from a physician - see "Physician Services"	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.**
- Office visits include a physical therapy evaluation or re-evaluation; occupational therapy evaluation or re-evaluation; speech or swallowing evaluation.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient" and "Hospital Outpatient."
- For lab and diagnostic imaging services billed by a health care professional, please refer to "Physician Services." For lab and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."

NOT COVERED:

- services primarily educational in nature, except as specified in the "Benefit Chart"
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return 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
- physical, occupational, and speech therapy services for learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training; including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc., and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and 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	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.
• Office visit for Urgent Care	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.
• E-Visit	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.
• Office Visit at a Retail Health Clinic	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.
• 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.	80% 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.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Allergy testing, serum, and injections	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.

PHYSICIAN SERVICES (continued)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Lab	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.
• Diagnostic imaging	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.**
- 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.
- Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- You are entitled to receive care at the In-Network level from Out-of-Network Providers if these services are covered under your Plan:
  - § 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. Please 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 this 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 physician time.
- The Plan covers hearing aid exams/fitting/adjustments for children age 18 and younger.
- 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.
- E-Visit is an online evaluation and management service provided by a physician using the Internet or similar secure communications network to communicate with an established patient.
- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- For hospital/facility charges for bariatric surgery, please refer to "Bariatric Surgery."

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- 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

NOT COVERED:

- separate charges for pre- and post-operative care for surgery
- 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"
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- physician dispensed self-administered prescription drugs for reproduction treatment
- please refer to the "General Exclusions" section

PRESCRIPTION DRUGS AND INSULIN

The Plan Covers:	Participating Pharmacy	Nonparticipating Pharmacy
• Prescription drugs § insulin § prescribed drug therapy supplies § prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for identified Specialty drugs (see below) § smoking cessation drugs § amino acid-based elemental formula § prescription prenatal vitamins § prescription pediatric multivitamins with fluoride § over-the-counter nicotine replacement products	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. Please refer to "Prescription Drugs" in the "Benefit Summary." Once you have reached the Prescription Drug Out-of-Pocket Maximum, your prescription is covered in full to the end of the calendar year.	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. Please refer to "Prescription Drugs" in the "Benefit Summary."
• Designated Over-the-Counter (OTC) drugs with a prescription	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. Please refer to "Prescription Drugs" in the "Benefit Summary."	**NO COVERAGE.**
• Designated Specialty drugs purchased through a specialty pharmacy network supplier	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 of a specialty drug at a Specialty pharmacy network supplier. Please refer to "Prescription Drugs" in the "Benefit Summary." Once you have reached the Prescription Drug Out-of-Pocket Maximum, your prescription is covered in full to the end of the calendar year.	**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 www.bluecrossmn.com 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 we have negotiated with participating pharmacies for that prescription drug.

NOTES:

- 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 www.bluecrossmn.com or contact Customer Service to locate a retail pharmacy participating in the 90dayRx Network or a Mail Service Pharmacy.
- Specialty drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated Specialty prescription drugs and suppliers is available at www.bluecrossmn.com or contact Customer Service. Specialty drugs are not available through 90dayRx.
- If you are prescribed a medication subject to Step Therapy, another eligible medication in the same or different drug class must have been prescribed and tried before the medication subject to Step Therapy will be paid under the drug benefit. Step Therapy drug categories are available on our website at www.bluecrossmn.com or contact Customer Service.
- 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 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 in 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.
- Over-the-counter nicotine replacement products require a prescription and are subject to your prescription drug cost-sharing unless you are a participant in Stop-Smoking Support where over-the-counter nicotine replacement products will be provided for you.
- 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. When you have reached your Prescription Drug Out-of-Pocket Maximum, you still pay the difference in cost between the brand name and the generic drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing.
- The Plan will cover off-label drugs used for cancer treatment as specified by law.
- When identical chemical entities including Over-the-Counter (OTC) drugs and a similar prescription alternative are from different manufacturers or distributors, the Blue Cross Coverage Committee may determine that only one (1) of those drug products is covered and the other equivalent products are not covered.
- Antipsychotic drugs and formulary drugs prescribed to treat emotional disturbance or mental illness will be covered on the same basis (applicable level) as all other eligible prescription drugs, unless the drug was removed from eligibility for safety reasons. Please refer to "Prescription Drugs" in the "Benefit Summary."
- To locate a Participating Pharmacy in your area, call the pharmacy information number provided in the "Customer Service" section.
- For drugs dispensed and used during an admission, please refer to "Hospital Inpatient."
- For supplies or appliances, except as provided in this Benefit Chart, please refer to "Medical Equipment, Prosthetics and Supplies."
- Self-administered injectable and oral prescription drugs for reproduction treatments must be obtained through a Specialty pharmacy network supplier and are subject to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
- 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.
- We 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 Blue Cross and/or the group contractholder and will not be considered in calculating any coinsurance, copay, or benefit maximums.

NOT COVERED:

- Specialty drugs not purchased through a Specialty pharmacy network supplier
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and except as specified in the "Benefit Chart"
- drugs removed from the formulary due to safety reasons may not be covered
- charges for giving injections that can be self-administered

PRESCRIPTION DRUGS AND INSULIN (continued)

NOT COVERED:

- over-the-counter drugs, except as specified in the "Benefit Chart"
- vitamin or dietary supplements, except as specified in the "Benefit Chart"
- investigative or non-FDA approved drugs, except as required by law
- smoking cessation drugs without a prescription or documented enrollment in Stop-Smoking Support
- nonprescription 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
• Health care 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	100%	100%, plus you pay any charges billed to you that exceed the Allowed Amount.
§ Infants and children	100%	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
§ Prenatal care	100%	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Preventive care services comply with state and federal statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit www.bluecrossmn.com or contact Customer Service.
- 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.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP or HRSA recommendations may be covered under other Plan benefits. Please refer to "Hospital Inpatient," "Hospital Outpatient," "Physician Services," etc. for appropriate benefit levels.

NOT COVERED:

- services you receive from an Out-of-Network Provider
- services for or related to surrogate pregnancy including, diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining 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
- educational classes or programs, except educational classes or programs required by law
- services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Benefit Chart"
- treatment, services or supplies which are investigative or not medically necessary
- please refer to the "General Exclusions" section

RECONSTRUCTIVE SURGERY

The Plan Covers:	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 when services are scheduled or initiated prior to the member turning age 19, including dental implants • Elimination or maximum feasible treatment of port wine stains	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.**
- Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses 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.
- For hospital/facility charges, please refer to "Hospital Inpatient" and "Hospital Outpatient."

NOT COVERED:

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

REPRODUCTION TREATMENTS

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Professional services for: § Artificial Insemination (AI) and Intrauterine Insemination (IUI) procedures § Non-investigative Assisted Reproductive Technologies (ART) § Drugs administered by a health care professional for eligible reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Outpatient hospital/facility services for: § AI and IUI procedures § Non-investigative ART § Drugs administered by a health care professional for eligible reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Professional lab services associated with reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Hospital/facility lab services associated with reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Professional diagnostic imaging services for reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.

REPRODUCTION TREATMENTS (continued)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospital/facility diagnostic imaging services for reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Self-administered injectable and oral prescription drugs	For the level of coverage refer to "Prescription Drugs and Insulin"	For the level of coverage refer to "Prescription Drugs and Insulin"

NOTES:

- **Please see the "Notification Requirements" section.**
- Please refer to the "Definitions" section for definitions of AI, IUI, and ART.
- Benefits are subject to a lifetime limit of $10,000 per person for all reproduction treatments for all charges and networks combined including self-administered injectable and oral outpatient prescription drugs.
- For services related to infertility testing, please refer to "Physician Services."

NOT COVERED:

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

SKILLED NURSING FACILITIES

The Plan Covers:	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.	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.**
- Coverage is limited to a maximum benefit of 120 days per person per calendar year.
- You must be admitted within 30 days after hospital admission of at least three (3) consecutive days for the same illness.
- Skilled care ordered by a physician includes skilled care ordered by an optometrist, chiropractor, or advanced practice nurse when ordered within the scope of their licensure.

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 a travel benefit available for expenses directly related to a preauthorized transplant. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.	*Participating Transplant Provider* 80% of the Transplant Payment Allowance after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount for the transplant admission. 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. *Nonparticipating Transplant Provider* **NO COVERAGE.**

NOTES:

- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient" and "Physician Services."
- **Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P.O. Box 64179, St. Paul, Minnesota 55164 or faxed to 651-662-1624.**

NOT COVERED:

- travel benefits when you are using a Non-BDCT Provider
- services you receive from a Nonparticiptating Transplant 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 transplant and peripheral stem cell transplant procedures that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this certificate
- please refer to the "General Exclusions" section

TRANSPLANT COVERAGE (continued)

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

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

WELL-CHILD CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• The following services for a dependent child from birth to age six (6): § preventive services § developmental assessments § laboratory services • Immunizations for a dependent child from birth to age 18	100%	80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOT COVERED:

- please refer to the "General Exclusions" section

BENEFIT SUBSTITUTION

Benefit substitution, a process of substituting one (1) covered benefit for another covered benefit, is used by our 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 our care/case managers, the patient or patient's representative(s), and health care provider. Our decision to use the benefit substitution process in a particular case in no way commits us to do so at another point in the same case or in another case, nor does it prevent us from strictly applying the express benefits, limitations and exclusions of the Plan at any other time or for any other insured person.

GENERAL EXCLUSIONS

We do not pay for:

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

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

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

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

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

6. Services for or related to therapeutic acupuncture, except for the treatment of chronic 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 for the treatment of an employment related injury for which you are entitled to make a worker's compensation claim unless the worker's compensation carrier has disputed the claim.

8. Charges that are eligible, paid, or payable under any automobile personal injury protection that is payable without regard to fault.

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

10. Services to treat injuries which occur while on military duty that are recognized by the Veterans Administration as services related to service connected injuries.

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

12. Services for dependents if you have group member-only coverage. If the group contractholder to whom the contract is issued offers dependent coverage, please refer to the "Eligibility" section on how to add dependents.

13. Services that are prohibited by law or regulation.

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

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

16. 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."

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

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

19. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.

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

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

22. 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.

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

24. 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).

25. 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."

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

27. 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.

28. Services for or related to therapeutic massage.

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

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

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

32. 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.

33. 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."

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

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

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

37. Services for or related to private-duty nursing, except as required by Minnesota law.

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

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

40. 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 us prior to receipt of services.

41. Services for or related to reversal of sterilization.

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

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

44. Donor ova or sperm.

45. 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."

46. 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."

47. 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.

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

49. Blood pressure monitoring devices.

50. Foot orthoses, except as specified in the "Benefit Chart."

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

52. 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."

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

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

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

56. 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.

57. 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.

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

59. 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.

60. Custodial care.

61. 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.

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

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

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

65. 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."

66. 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 certificate; and kidney donor expenses when the recipient is not covered under this certificate.

67. Services for or related to any treatment, equipment, drug, and/or device that 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 is not medically necessary.

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

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

70. Autopsies.

71. Charges for failure to keep scheduled visits.

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

73. 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.

74. Services for or related to smoking cessation program fees and/or supplies.

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

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

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

78. Smoking cessation drugs without a prescription or documented enrollment in Stop-Smoking Support.

79. 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.

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

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

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

83. 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.

84. Services for or related to fetal tissue transplantation.

ELIGIBILITY

This certificate covers only those group members who work in the United States (U.S.) or its Territories. Group members who work and reside in foreign countries are not eligible for coverage. Group members who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Dependents

NOTE: A spouse who is covered as a group member under the group contractholder is not an eligible dependent. A child who is covered as a group member under the group contractholder or as a group member of any group contractholder is not an eligible dependent. If both parents are covered as group members under the contract, children may be covered as dependents of either parent but not both.

Spouse

Spouse, meaning:

1. opposite gender spouse to whom you are legally married. Contact your group contractholder to determine if any restrictions apply.

Dependent Children

1. Natural-born dependent children and/or stepchildren to the dependent child age limit specified in the "Benefit Summary."

2. Legally adopted children and children placed with you or your spouse for legal adoption to the dependent child age limit specified in the "Benefit Summary." 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. Dependent children for whom you or your spouse have been appointed legal guardian to the dependent child age limit specified in the "Benefit Summary."

4. Grandchildren to the dependent child age limit specified in the "Benefit Summary" who live with you or your spouse continuously from birth and are financially dependent upon you or your spouse.

5. Otherwise eligible children of the group member who are required to be covered by a reason of a Qualified Medical Child Support Order to the dependent child age limit specified in the "Benefit Summary."

Disabled Dependents

1. Unmarried disabled dependent children who reach the dependent child age limit specified in the "Benefit Summary" while covered under this Plan if all of the following apply:

    a. primarily dependent upon the group member; and
    b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness, or mental disorders; and
    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, we may request proof again two (2) years later, and each year thereafter; and
    d. must have become disabled prior to reaching the limiting age.

2. Disabled dependents if both of the following apply:

    a. incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
    b. chiefly dependent upon the group member for support and maintenance.

Effective Date of Coverage

Coverage starts on the date specified in the "Benefit Summary." This is the effective date for the group member and any dependents who were enrolled by written application before that date.

Coverage for the group member and any dependents who are eligible on the effective date of the contract begins on that date. Group members and dependents added after the original effective date of the contract are subject to the requirements outlined below:

1. When the group contractholder pays the entire monthly premium:

    - If we receive written application more than 30 days after you or your dependents become eligible (including instances where coverage has been waived), coverage will be effective on your or your dependents' eligibility date. We will backdate coverage for up to two (2) months from the date that we are notified to add you or your dependents. If your group contractholder has a graded contribution, we will not backdate coverage.

2. When you are responsible for all or a portion of the premiums:

    - If we receive written application more than 30 days after you or your dependents become eligible (including instances where coverage has been waived), coverage will start on the first day of the contract month following our receipt of application and contract premiums. If you or your dependents are considered late entrants, you will be subject to an 18-month preexisting condition limitation.

    - If we receive written application more than 30 days after you or your dependents become eligible (including instances where coverage has been waived), you or your dependents will be considered late entrants and must wait until the next annual open enrollment to apply unless you or your dependents meet the requirements of the Special Enrollment Period.

Adding New Dependents

We require payment of any required premiums and a written application, on our application form, to add a new dependent. Monthly premiums must be paid from the date coverage begins. This part outlines the time periods for application and the date coverage begins.

Adding a Spouse

When the group contractholder pays the entire monthly premium:

- Your spouse is covered starting on the date of marriage if you submit written application within 30 days after marriage. If we receive the application more than 30 days after the marriage, we backdate coverage to the date of marriage or two (2) months, whichever is less.

When you are responsible for all, or a portion of, the premiums:

- Your spouse is covered starting on the date of marriage if you submit payment of required premiums and written application within 30 days after marriage. If we do not receive written application to add your spouse within 30 days after the marriage, your spouse will be considered a late entrant. Late entrants will be subject to an 18-month preexisting condition limitation period.

- Your spouse is covered starting on the date of marriage if you submit payment of required premiums and written application within 30 days after marriage. If we do not receive written application to add your spouse within 30 days after the marriage, your spouse will be considered a late entrant and must wait until the next annual open enrollment to apply unless your spouse meets the requirements of the Special Enrollment Period.

Adding Newborns and Children Placed for Adoption

Your newborn child or newborn grandchild is covered starting on the date of birth. In order to avoid claim delays, we request that you submit payment of all required premiums and written application within 30 days after birth. If you submit an application more than 30 days after birth, your newborn child or newborn grandchild will still be added retroactive to the date of birth and you will be responsible for any premium due from the date of birth.

Your adopted child is covered starting on the date of adoption or placement with you for adoption. In order to avoid claim delays, we request that you submit payment of all required premiums and written application within 30 days after adoption or placement. If you submit an application more than 30 days after adoption or placement, your adopted child will still be added retroactive to the date of adoption or placement and you will be responsible for any premium due from the date of adoption or placement.

If we receive the application to add your newborn child, newborn grandchild or adopted child requesting an effective date later than the date of birth, adoption or placement, your newborn child, newborn grandchild or adopted child will be considered a late entrant unless your newborn child, newborn grandchild or adopted child meets the requirements of the special enrollment period. Late entrants are subject to an 18-month preexisting condition limitation period, with credit for continuous qualifying creditable coverage. Coverage for a late entrant starts on the first day of the month following our receipt of the written application and monthly premium.

If we receive the application to add your newborn child, newborn grandchild or adopted child requesting an effective date later than the date of birth, adoption or placement, your newborn child, newborn grandchild or adopted child must wait until the next annual open enrollment to apply unless your newborn child, newborn grandchild, or adopted child meets the requirements of the Special Enrollment Period.

Adding Disabled Dependents

Disabled dependents who are not currently covered under this certificate, may be added as long as they otherwise meet the definition of "dependent." See the "Definitions" section. Coverage starts on the first day of the contract month after we receive the written application and monthly premium. Disabled dependents added to the coverage under this certificate cannot be denied coverage or be subject to any preexisting condition limitation period.

Special Enrollment Periods

Special enrollment periods are periods when an eligible group member or dependent may enroll in the health 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 circumstance.

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

1. Loss of Group Health Plan Coverage

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

   a. the group member or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the group member or dependent;

   b. the group member 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 group member's or dependent's coverage is terminated because: his/her COBRA continuation has been exhausted (not due to failure to pay premium or for cause), he/she is no longer eligible for the plan due to a divorce, death of the group member, 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 group member or dependent requests enrollment not later than 30 days after the termination of coverage or employer contribution, or the meeting or exceeding of the lifetime limit on all benefits.

Coverage for group members or dependents (other than newborns, newborn grandchildren and children placed for adoption – see "Eligibility" section) who are eligible to enroll in the Plan under the Special Enrollment Periods provision will be effective the day after the termination of prior coverage or the date of 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

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

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

   b. the group member 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 group member or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

3. Eligibility for Premium Assistance

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

   a. the employer must submit any required documentation indicating that the group member and/or dependents are eligible for premium assistance through Medicaid or CHIP; and;

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

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

Termination of Coverage

If coverage is terminated for all group members in your Plan, we will give all group members a 30-day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months. We will not give this notification if we have reasonable evidence to indicate that this coverage will be replaced by a similar policy, plan or contract.

Coverage ends on the earliest of the following dates:

1. The last day of the contract month that required premiums are paid for your coverage if we do not receive payment when due. Your payment of premiums to the group contractholder does not guarantee coverage unless we receive full payment when due.

2. For all group members and dependents, the last day of the contract month the group member is no longer eligible as defined in the group contractholder's contract with us.

3. The last day of the contract month you or your dependents enter military service for duty lasting more than 31 days.

4. The date charges are incurred that result in payment up to your lifetime maximum.

5. For dependents, the date the dependent is no longer eligible for coverage. This is the last day of the contract month that:

    a. The group member and spouse divorce or legally separate, for the ex-spouse/spouse and any covered stepchildren.

    b. The dependent child reaches the dependent child age limit specified in the "Benefit Summary," except where a child may be classified as a disabled dependent, in which case coverage may be continued if you submit payment of all required premiums and written application within 31 days after your dependent becomes disabled. If we do not receive payment of required premiums and written application within 31 days after the date of becoming disabled, coverage starts on the first day of the contract month after we receive the application.

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

6. The last day of the contract month that the group member requests that coverage be terminated.

7. With respect to a specific coverage item, the date coverage ends or the individual maximum has been reached.

8. The last day of the contract month that the group member retires or is pensioned unless the group contract contains a specific classification for retired or pensioned employees.

9. The date we determine an enrollee committed fraud or misrepresentation with respect to eligibility or any other material fact subject to the "Time Limit for Misstatements" provision.

Please provide notification to your group contractholder within 63 days of any changes in your dependent's eligibility so we can provide you with continuation of coverage options. Refer to the "Continuation of Coverage" section and the "Portability" section of this certificate for information regarding extension of coverage, or how to obtain an individual qualified plan.

Certification of Coverage

When you or your dependents terminate coverage under this certificate, a certification of coverage form will be issued to you specifying your coverage dates under this certificate and any probationary 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 towards 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 group and, if applicable, at the expiration of any continuation period. We will also issue the certification of coverage form if you request a copy at any time within the 24 months after your coverage terminates. To request a Certification of Coverage form, please contact us at the address or telephone number listed in the "Customer Service" section or refer to your Identification (ID) card.

Extension of Benefits

If you are confined as an inpatient on the date your coverage ends due to the replacement of the group contract, we automatically extend coverage until the date you are discharged from the facility or the date contract 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 group contract terminates and the group contractholder obtains continuous group coverage with a new carrier.

CONTINUATION OF COVERAGE

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 ***group member*** 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 (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment).
- Total disability - Total disability means the ***group member's*** inability to engage in or perform the duties of the ***group member's*** regular occupation or employment within the first two (2) years of disability. After the first two (2) years, it means the ***group member's*** inability to perform any occupation for which the ***group member*** is educated or trained.

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

- The death of the ***group member***.
- A termination of the ***group member's*** employment (as described above) or reduction in the ***group member's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***group member***. (This includes if the ***group member*** 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 administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The ***group member*** becomes enrolled in Medicare.
- The ***group member*** becomes totally disabled (as defined above).

A ***dependent child*** of a covered ***group member*** 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 ***group member***.
- The termination of the ***group member's*** employment (as described above) or reduction in the ***group member's*** hours of employment with the employer.
- Parents' divorce or legal separation.
- The ***group member*** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under this group contract.
- The total disability of the ***group member*** (as defined above).

Your Notice Obligations

You and your dependents must notify the group contractholder 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 group contract'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 dependent 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 group contractholder of a divorce, legal separation or a loss of dependent status the group contractholder will notify the affected family member(s) of the right to elect continuation coverage. If you notify the group contractholder of a qualifying event or disability determination and the group contractholder determines that

there is no extension available, the group contractholder will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

Group Contractholder's and Plan Administrator's Notice Obligations

The group contractholder has 30 days to notify the plan administrator of events they know have occurred, such as termination of employment or death of the ***group member***. This notice to the plan administrator does not occur when the plan administrator is the ***group contractholder.*** 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 group contractholder 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 ***group member's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***group member'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, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage. In addition, a dependent may elect continuation coverage even if the covered ***group member*** 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 group contractholder 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 group contract 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 ***group member*** 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 group 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 ***group member's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

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

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

Continuation Premiums

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

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

  Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the plan administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***group member's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the group contract 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 ***group member'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 ***group member's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month or an indefinite maximum coverage period. The extension applies to the ***group member'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 within the required 60-day period, no extension will occur.

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

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

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

- **Group Contractholder'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, we include it here. If the group contractholder 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 group contract, 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 ***group member*** and dependents will automatically terminate when any one of the following events occur:

- The group contractholder no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- After electing continuation, you or your dependents become covered under another group health plan that has no exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered ***group members*** 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 Group Member During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***group member*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***group member*** 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 ***group*** member.

Open Enrollment Rights and Special Enrollment Rights

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

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

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

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 section. For more detail refer to the previous section.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Group member 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 that lose coverage	Earlier of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise end.
Death of group member	Surviving spouse and dependent children	Earlier of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise end if the group member 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 group member'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 group contractholder filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation:
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Total disability of group member	Group member and dependents	Earlier of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Extensions to 18-month maximum continuation period: Total disability of dependent(s)	Disabled dependent and all other covered family members	Earliest of: 1. 29 months after the group member leaves employment, or 2. Date total disability ends, or 3. Date coverage would otherwise end.

Additional Event

In addition to the events outlined above, you may choose to continue your coverage during an approved leave of absence or vacation by paying the monthly required premiums to your group contractholder in the manner required by your group contractholder. Coverage may be continued for six (6) months after the end of the Plan month during which the temporary leave began.

PORTABILITY

You may convert your coverage to an individual qualified plan if your coverage ends because:

1. your group contract ends and is not replaced with other continuous group coverage; or

2. you or your dependents exhaust the maximum period of continuation coverage as described in the "Continuation of Coverage" section of this certificate; or

3. you or your dependents become ineligible for coverage under this certificate and continuation of coverage is not available to you or your dependents because a qualifying event has not occurred.

If your coverage ends because the group contract ends, you must apply for portability coverage within 63 days after receiving notice of cancellation of the group contract.

If your coverage ends because you become ineligible or exhaust your continuation rights, you must apply for portability coverage within 63 days after your coverage or continuation ends.

Portability coverage and premiums will not be the same as the group contract. Evidence of good health is not required. Regardless of the reason coverage ends, you are not eligible for portability coverage if you are covered under another qualified plan or you do not make timely application.

If you apply within 63 days of losing prior coverage, your portability coverage will be effective as of the day following your loss of group coverage if you pay the required premium.

COORDINATION OF BENEFITS

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

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

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

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

   c. individual coverage.

   "Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

   If any of the above coverages include group and group-type hospital indemnity coverage, "Plan" only includes that amount of indemnity benefits which exceed $100 a day.

   Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.

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

3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

   When This Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When This Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When you are covered under more than two (2) plans, This Plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.

   Notes:
   a. If you are covered under This Plan and Medicare: This Plan will comply with the 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 Benefits 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 item 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 of expense that exceeds benefits that are limited by statute or This Plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number 3 above).

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

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

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

Order of Benefits Rules

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

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

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

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

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

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

      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

   c. Dependent child of parents divorced or separated. If two (2) or more plans cover a child dependent of divorced or separated parents, we determine 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.

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

   d. Active/inactive group member. The plan that covers a person as a group member who is neither laid-off nor retired (or as that group member's dependent) determines benefits before a plan that covers that person as a laid-off or retired group member (or as that group member's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.

   e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the plan that has covered a group member longer determines benefits before the plan that has covered that person for the shorter time.

Effect on Benefits of This Plan

1. When this section applies:

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

2. Reduction in This Plan's benefits:

   When the sum of:

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

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

      When benefits of This Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. We have the right to decide which facts are needed. We may get needed facts from, or give them to, any other organization or person. We do not need to tell or get the consent of any person to do this, unless applicable federal or state law prevents disclosure of information without the consent of the patient or patient's representative. Each person claiming benefits under this Plan must give us 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, we may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. We 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 we pay more than we should have paid under these coordination of benefit rules, we may recover the excess from any of the following:

1. the persons we paid or for whom we have paid;
2. insurance companies; or
3. other organizations.

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

REIMBURSEMENT AND SUBROGATION

We maintain both a right of reimbursement and a right of subrogation. If we pay benefits for medical or dental expenses you incur as a result of any act of a third party for which the third party is or may be liable, and you later obtain full recovery, you are obligated to reimburse us for the benefits paid under this coverage. We are entitled to subrogate or be reimbursed by you for any and all compensation or payments received whether as a result of settlements or judgments, including any amounts you may receive from your own insurers.

However, our right to reimbursement and subrogation is subject to you obtaining full recovery and subtraction for actual monies paid to account for the pro rata share of your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source, in accordance with Minnesota Statutes 62A.095 and 62A.096, the laws relating to subrogation and reimbursement rights and obligations.

Nothing herein shall limit our right to recovery from another source which may otherwise exist at law. For purposes of this provision, full recovery does not include payments made by us or for your benefit.

Notice Requirement

You (or your attorney) must provide timely written notice to us of the pending or potential claim, if you make a claim against a third party for damages that include repayment for medical and medically related expenses incurred for your benefit. Your obligation to give us this notice is stated in Minnesota Statute 62A.096. Notwithstanding any other law to the contrary, the statute of limitations applicable to our rights for reimbursement or subrogation does not commence to run until the notice has been given.

GENERAL PROVISIONS

Claims Filing

You are not responsible for submitting claims for services received from In-Network Providers. These providers will submit claims directly to us for you and payment will be made directly to them. If you receive services from Out-of-Network Providers, you may have to submit the claims yourself. If the provider does not submit the claim for you, send the claim to us at the address provided in the "Customer Service" section.

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

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

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

Right of Examination

We have the right to ask you to be examined by a provider during the review of any claim. We choose the provider and pay for the exam whenever we request this. Failure to comply with this request may result in denial of your claim.

Release of Records

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

Entire Contract

This certificate and the group contract issued to the group contractholder make up the entire contract of coverage. The master group contract is available for your inspection at your group contractholder's office. Your group contractholder is the Plan Administrator for your coverage plan. We have discretionary authority to determine your eligibility for benefits and to construe the provisions of the group contract and this certificate. This certificate is issued and delivered in the state of Minnesota, is subject to the laws of the state of Minnesota, and is not subject to the laws of any other state.

Time Limit for Misstatements

If there is any misstatement in the written application that the group contractholder completes, we cannot use the misstatement to cancel coverage that has been in effect for two (2) years or more. This time limit does not apply to fraudulent misstatements.

Changes to the Contract

The group contractholder reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan. Any amendment to this Plan may be effected by a written resolution adopted by a majority of the Benefit Committee/Insurance Committee/Board of Directors of the company. Blue Cross will communicate any adopted changes to the group contractholder.

All changes to the group contract must be approved by one (1) of our executive officers and attached to the group contract with the group contractholder. No agent can legally change the group contract or waive any of its terms.

Carrier Replacement

If you were covered under a fully insured health plan prior to the effective date of this health plan, the Minnesota Carrier Replacement law applies. Under the Minnesota Carrier Replacement law, you cannot be denied benefits solely because there has been a change in the carrier providing coverage to the group contractholder's group.

If you are inpatient on the effective date of this coverage, the prior carrier is responsible for all eligible expenses until your final discharge from the inpatient facility or until contract maximums have been met.

In applying any deductible or waiting period, this health plan gives credit for the full or partial satisfaction of the same or similar provisions under the prior contract.

Whom We Pay

When you use a Participating Provider for covered services, we pay the provider. When you use a Nonparticipating Provider for covered services, we pay you. You may not assign your benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may ask us to pay a Nonparticipating Provider for covered services for a child. When we pay the provider at the request of the custodial parent, we have met our obligation under the contract.

This provision may be waived for certain out-of-state institutional and medical/surgical providers.

Blue Cross does not pay claims to providers or to members 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 are authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

Legal Actions

No legal action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Employee Retirement Income Security Act (ERISA) Statement of Rights

If you are covered by a contract issued to your employer that is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine without charge, at the group contractholder'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 group contractholder, 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 certificate of coverage. The group contractholder may make a reasonable charge for the copies.

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

2. 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 certificate of coverage 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 qualifying creditable coverage from another plan. You should be provided a certificate of qualifying 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 qualifying creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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.

4. 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 group contractholder to provide you 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 group contractholder. 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 disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan 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 those costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

If you have any questions about your Plan, you should contact the group contractholder. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the group contractholder, 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 N. W., 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.

COMPLAINT PROCESS

Introduction

Blue Cross has a process to resolve complaints. You can call or write us with your complaint. We will send a complaint form to you upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature. We will work to resolve your complaint as soon as possible using the process outlined below.

If your complaint concerns a covered health care service or claim, you may request an external review of the final decision we make about your appeal after you have exhausted the Blue Cross appeal process.

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

Definitions

Complainant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits a complaint.

Complaint means any grievance that is not the subject of litigation concerning any aspect of the provision of health services under your certificate of coverage. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former member, the complaint must relate to the provision of health services during the period of time the complainant was a member.

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

Any grievance that requires a medical determination in its resolution must have the medical determination aspect of the complaint processed under the utilization review process described below.

Process for Complaints that do not Require a Medical Determination

Verbal Notification

If you call or appear in person to notify us that you would like to file a complaint, we will try to resolve your oral complaint within 10 days. If our resolution of your oral complaint is wholly or partially adverse to you, we will provide you a complaint form that will include all the necessary information to file your complaint in writing. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

Written Notification

You may submit your complaint in writing, or you may request a complaint form that will include all the necessary information to file your complaint. Blue Cross will notify you that we have received your written complaint.

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

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

Voluntary Appeal

If our decision is partially or wholly adverse to you, you may file a voluntary appeal of the decision in writing and request either a hearing or a written reconsideration. Our appeals committee will not consist solely of the same person or persons who made the initial complaint decision that is being appealed.

Hearings include the receipt of testimony, correspondence, explanations or other information from you, staff persons, administrators, providers, or other persons as deemed necessary by the presiding person or persons for the fair appraisal and resolution of the appeal.

In the case of a hearing, concise written notice of our decision and all key findings will be given to you within 45 days after we receive your written notice of appeal.

Written reconsiderations include the receipt of correspondence, explanations or other information from you, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons conducting the appeal for the fair appraisal and resolution of the appeal.

In the case of a written reconsideration, concise written notice of our decision and all key findings will be given to you within 30 days after we receive your written notice of appeal.

If you request, we will provide you a complete summary of the appeal decision.

External Review

If your complaint concerns a covered health care service or claim and you believe Blue Cross' voluntary appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf, may submit the adverse determination to external review. You may submit an adverse determination to external review at any time, and are not required to use Blue Cross' voluntary appeal process first. External review of your complaint will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Commerce along with a filing fee. The Commissioner may waive the fee in cases of financial hardship.

Minnesota Department of Commerce
Attention: Enforcement Division
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

The external review entity will notify you and Blue Cross that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and Blue Cross must provide the external review entity any information to be considered. Both you and Blue Cross will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, Blue Cross, and the Commissioner within 40 days of receiving the request for external review. The external review entity's decision is binding on Blue Cross, but not binding on you.

Process for Complaints When Utilization Review is Necessary

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

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

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

Definitions

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

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

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

Provider means a health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider.

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

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

Determinations

Standard review determination

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

Expedited review determination

Blue Cross will use an expedited review determination if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify the attending health care professional, hospital and member of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from the initial request. If the expedited determination is to not authorize services, notification will include notice that you and your attending health care professional may submit an expedited appeal, and how to submit an expedited appeal.

Appeals

Standard appeal

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

The request for appeal should include:

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

Expedited appeal

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

External Review

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

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

DEFINITIONS

Please refer to the "Benefit Summary" and "Benefit Charts" for specific benefits and payment information.

Term	Definition
90dayRx	Participating 90dayRx Retail Pharmacies and Mail Service Pharmacy used for the dispensing of a 90-day supply of long-term prescription drug refills.
Admission	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
Advanced Practice Nurses	Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
Aftercare/ Continuing Care Services	The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.
Allowed Amount	The amount upon which we base payment 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. We 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 we use a reasonable allowance to establish a per-service Allowed Amount for such covered services. Through settlements, rebates, and other methods, we 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 us or the contractholder, and the percentage of the Allowed Amount paid by us 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, we pay that cost on your behalf, and the percentage of the Allowed Amount paid by us 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, Blue Cross makes no representations that this amount is intended to represent a usual, customary or reasonable charge.

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 www.bluecrossmn.com. You may also contact 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 Blue Cross 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.

The Allowed Amount for all other Nonparticipating Providers (Facility Services) in Minnesota

The Blue Cross and Blue Shield of Minnesota 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 subject to business rules established in the Blue Cross 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 all other 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, Blue Cross will use the Allowed Amount for Nonparticipating Providers in Minnesota.

The Allowed Amount for Nonparticipating Providers (Facilities 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.

Term	Definition
	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 Blue Cross 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 a preserved specimen), into a woman's vagina, cervical canal, or uterus by means other that sexual intercourse.
Assisted Reproductive Technology (ART)	Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine, or artificial insemination), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.
Attending Health Care Professional	A health care professional with primary responsibility for the care provided to a sick or injured person.
Average Semiprivate Room Rate	The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, we use the average private room rate for payment of the claim.
Behavioral Health Care Treatment	Treatment for mental health disorders and substance abuse/addiction diagnoses as listed in the most recent edition of the *International Classification of Diseases*. Does not include developmental disability.
Behavioral Health Select Network Provider	A health professional that participates in a special network for the provision of certain covered treatment services.
Behavioral Health Therapy	A method of treating mental and substance abuse disorders that involves verbal and nonverbal communication about thoughts, feelings, emotions and behaviors in individual, group or family sessions in order to change unhealthy patterns of coping, relieve emotional distress and encourage improved interpersonal relations.
Benefit Chart	The schedule that lists benefits and covered services.
Benefit Summary	The pages attached to this certificate which list items such as deductible amounts, out-of-pocket maximums, preexisting condition limitation periods, etc.
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 Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use Participating Providers of a Host Blue and show your membership ID to secure BlueCard Program access.

Term	Definition
Blue Select Provider	A health care professional that participates in a special network for the provision of certain covered services.
Calendar Year	The period starting on January 1st of each year and ending at midnight December 31st of that year.
Care/Case Management Plan	A plan for health care services developed for a specific patient by one of our care/case managers after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.
Certification of Coverage	A form which will be issued when health coverage is terminated under this certificate. The Certification of Coverage form will contain the necessary information a new health plan will need to apply the appropriate credit toward the new health plan's preexisting condition limitation period.
Claims 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 until you reach your out-of-pocket 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 us will be greater than the stated percentage. For covered services from Nonparticipating Providers, coinsurance is calculated based on the Allowed Amount. In addition, you are responsible for any excess charge over the Allowed Amount. Your coinsurance and deductible amount will be based on the negotiated payment amount Blue Cross 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 network contract with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we 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 we pay 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 our Allowed Amount when a Nonparticipating Provider is used. For example, if a Nonparticipating Provider ordinarily charges $100 for a service, but our Allowed Amount is $95, we will pay 80% of the Allowed Amount ($76). You must pay the 20% coinsurance on our 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 our Allowed Amount. If Nonparticipating Providers are used, your out-of-pocket costs will be higher as shown in the example above.

Term	Definition
Compound Drug	A prescription where two (2) or more medications are mixed together. One (1) of these drugs must be a federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added.
Comprehensive Pain Management Program	A multidisciplinary program including, at a minimum, the following components: 1. a comprehensive physical and psychological evaluation; 2. physical/occupational therapies; 3. a multidisciplinary treatment plan; and 4. a method to report clinical outcomes.
Continuous Qualifying Creditable Coverage	The maintenance of continuous and uninterrupted qualifying creditable coverage by an eligible group member or dependent. An eligible group member or dependent is considered to have maintained continuous qualifying creditable coverage if the individual applies for coverage within 63 days of the termination of his/her qualifying creditable coverage.
Copay	The dollar amount you must pay for certain covered services. The "Benefit Summary" 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 we begin to pay benefits. The deductibles for each person and family are specified in the "Benefit Summary." Your coinsurance and deductible amount will be based on the negotiated payment amount Blue Cross 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 Blue Cross may receive from other parties.

Term	Definition
Dependent	Your spouse, child to the dependent child age limit specified in the "Benefit Summary," child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the "Benefit Summary," unmarried grandchild who meets the eligibility requirements as defined in the "Eligibility" section to the age specified in the "Benefit Summary," 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 is 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 Blue Cross 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 that 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.

Term	Definition
Group Contractholder	The employer or association to which the group contract is issued.
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 Member	The employee, association member or employee, shareholder or employee for whom coverage has been provided by the group contractholder or association.
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 facilities 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 care 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 inpatient hospital 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	In Minnesota, a provider that has entered into a specific network contract with us. Outside of Minnesota, a provider that has entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan. Please refer to the "Benefit Summary" 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.
Inpatient Care	Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Term	Definition
Intensive Outpatient Programs (IOPs)	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 we start to pay 100% for certain covered services for the rest of the year. Your Allowed Amounts must total the intermediate maximum specified in the "Benefit Summary."
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, medical or behavioral health treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We base our 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, medical or behavioral health 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, medical or behavioral health 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	An eligible group member or dependent who requests enrollment under the Plan after the enrollment period during which the individual first became eligible for coverage. Late entrants will be subject to a preexisting condition limitation period, with credit for 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 us 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 or legal separation, death, termination of employment, reduction in hours, or employer contributions toward the coverage were terminated; 4. the individual is a new spouse of an eligible group member applying for coverage within 30 days of becoming legally married; 5. the individual is a new dependent of an eligible group member for whom coverage is being requested within 30 days of becoming a new dependent;

Term	Definition
	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 group member 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 with the group contractholder. The lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copays, and other amounts. Refer to the "Benefit Summary" for specific dollar maximums on certain services.
Mail Service Pharmacy	A pharmacy that dispenses prescription drugs through the U.S. Mail.
Marital/Couples Therapy/Counseling	Behavioral health care services for the primary purpose of working through relationship issues.
Marital/Couples Training	Services for the primary purpose of relationship enhancement 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 credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Medicare	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost-sharing requirements and certain benefit limitations.
Mental Health Care Professional	A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders, substance abuse, or addiction.
Mental Illness	A mental disorder as defined in the *International Classification of Diseases*. It does not include substance dependence, nondependent substance abuse, or developmental disability.

Term	Definition
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 who has not entered into a network contract with us 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 considered In-Network; and, Nonparticipating Providers.
Out-of-Pocket Maximum	The most each person must pay each year toward the Allowed Amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the Allowed Amount for covered services for that person for the rest of the year. The "Benefit Summary" 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 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 us or the local Blue Cross and/or Blue Shield Plan.
Pharmacy Value Based Benefit Design	A program designed to reward ongoing appropriate drug usage by providing reduced member cost-sharing for medications in specific categories or drug classes.
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.

Term	Definition
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 we have determined existed up to six (6) months preceding the enrollment date of your coverage. Conditions are considered to be preexisting if medical advice, diagnosis, care, or treatment was recommended or received within the specified time period. Preexisting condition does not include genetic information alone in the absence of a diagnosis for a condition related to the genetic information, or an existing pregnancy.
Preexisting Condition Limitation Period	The time period based on your enrollment date of your coverage during which services related to preexisting conditions will not be covered under this health benefit plan.
Prescription Drug Out-of-Pocket Maximum	The most each person must pay toward the Allowed Amount for prescription drugs per year. After a person reaches the prescription drug out-of-pocket maximum, we pay 100% of the Allowed Amount for covered services for the rest of the year. The "Benefit Summary" 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 the 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 includes 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; *TRICARE;* the Minnesota Comprehensive Health Association (MCHA); 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 Corp 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, or any political subdivision of 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 a 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 medication, 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 inpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite Care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.

Term	Definition
Retail Health Clinic	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Retail Pharmacy	Any licensed pharmacy that you can physically enter to obtain a prescription drug.
Semiprivate Room	A room with two (2) beds.
Services	Health care services, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.
Skilled Care	Services that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a 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: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.
Specialty Pharmacy Network	A nationwide pharmaceutical specialty provider that participates in a network for the dispensing of certain oral medications and injectable drugs.
Step Therapy	Step Therapy includes, 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 professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S., or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Term	Definition
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; and 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 communication between a distant site health care professional and the patient whom is present and participating in the televideo visit at a remote facility.
Terminally Ill Patient	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
Therapeutic Camps	A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.
Therapeutic Day Care (Pre-School)	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreation 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 illness or injury. Treatment includes medical care and surgical diagnostic evaluation, giving medical advice, monitoring and tracking medication.
Waiting Period	The period of time that must pass before you or your dependents are eligible for coverage under the health plan.