

**COMPREHENSIVE  
MAJOR MEDICAL  
HEALTH CARE PLAN**



*For Employees of:*

**St. Olaf College**

*(herein called the Plan Administrator or the Employer)*



# ANNUAL NOTIFICATIONS

## ***Women's Health and Cancer Rights Act***

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

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

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

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

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under this Plan and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.**

### **THE PLAN ADMINISTRATOR HAS DETERMINED THAT PRESCRIPTION DRUG COVERAGE UNDER THIS PLAN IS CREDITABLE.**

- 1. Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription plans and Medicare Advantage Plans that offer prescription drug coverage in 2006. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may offer more coverage for a higher monthly premium.**
- 2. The Plan Administrator has determined that the prescription drug coverage offered by this Plan is, on average for all participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage. Because your prescription drug coverage is, on average for all participants, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and you will not pay extra if you decide later to enroll in Medicare prescription drug coverage.**
- 3. Please contact Customer Service using the telephone number in the Customer Service section for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.**

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage under this Plan and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your premium will go up at least one percent per month for every month after May 15, 2006 that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay.

**For more information about this notice or your current prescription drug coverage, contact Customer Service using the telephone number provided in the Customer Service section.**

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, or if coverage under this Plan changes. You may also request a copy.

**For more information about your options under Medicare prescription drug coverage...**

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

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call Customer Service using the telephone number provided in the Customer Service section.
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help for paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or you can call them at 1-800-722-1213 (TTY 1-800-325-0778.)

**REMEMBER: Keep this notice. If you enroll in one of the prescription drug plans approved by Medicare, you may be required to provide a copy of this notice when you join.**



# RIGHTS AND RESPONSIBILITIES

## ***Your Rights Under This Plan:***

- To be treated with respect and dignity.
- To receive quality health care that is friendly and timely.
- To receive available and accessible medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week.
- To 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.
- To participate with your health care providers in decisions about your treatment.
- To 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).
- To refuse treatment.
- To privacy of medical and financial records maintained by the Plan, the Claims Administrator, and its health care providers in accordance with existing law.
- To receive information about the Plan, its services, its providers, and your rights and responsibilities.
- To make recommendations regarding these rights and responsibilities policies.
- To have a resource at the Plan, the Claims Administrator or at the clinic that you can contact with any concerns about services.
- To file an appeal with the Claims Administrator and receive a prompt and fair review.
- To initiate a legal proceeding when experiencing a problem with the Plan or its providers.

## ***Your Responsibilities Under This Plan:***

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



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# INTRODUCTION

This Summary Plan Description (SPD) contains a summary of the St. Olaf College Comprehensive Major Medical Health Care Plan for benefits effective September 1, 2007.

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

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

This Plan, financed and administered by St. Olaf College, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (BCBSM) is the Claims Administrator and provides administrative services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this Summary Plan Description, 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 service agreement with the Claims Administrator to provide you quality health services at favorable prices. These providers are also referred to as Participating Providers.

The Plan also provides benefits for covered services you receive from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers are also referred to as Nonparticipating Providers. Nonparticipating Providers have not entered into a service agreement with the Claims Administrator. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

**IMPORTANT!** When receiving care, present your identification card to the provider who is rendering the services. It is also important that you read this entire Summary Plan Description carefully. It explains the Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. If you have questions about your coverage, please contact the Claims Administrator at the address or phone numbers listed on the following page.

# CUSTOMER SERVICE

**Questions?**

The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for preadmission and emergency admission notification.

Monday through Thursday: 7:00 am - 5:30 pm CT  
Friday: 9:00 am - 4:30 pm CT

Hours are subject to change without prior notice.

**Customer Service Telephone Number**

Claims Administrator: (651) 662-5001 or toll free at 1-800-531-6681

**Blue Cross Blue Shield of Minnesota Website**

<http://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**

<http://www.bcbs.com>

This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.

**Claims Administrator's Mailing Address**

Claims review requests, and written inquiries may be mailed to the address below:

Blue Cross and Blue Shield of Minnesota  
P.O. Box 64338  
St. Paul, MN 55164

Prior authorization requests should be mailed to the following address:

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

**Pharmacy Telephone Number**

Toll free 1-800-509-0545  
This number is used to locate a participating pharmacy.

**FirstHelp™ Telephone Number**

Toll free 1-800-622-9524  
This number is used to access health care advice 24 hours a day – seven days a week.

**BluePrint for Health® stop-smoking program**

Toll free 1-888-662-BLUE (2583)  
This number is used to enroll in the BluePrint for Health stop-smoking program

# SPECIAL FEATURES

## FirstHelp

FirstHelp is a program that allows you access to health care advice 24 hours a day – seven days a week. Specially trained nurses can help you make an informed decision about whether to see a doctor or care for your sickness or injury at home. The FirstHelp™ telephone number is 1-800-622-9524.

## Stop-Smoking

The BluePrint for Health stop-smoking program is a telephone based service designed to help you quit using tobacco. There is no charge for this service.

To participate, call BluePrint for Health at 1-888-662-BLUE (2583). A tobacco cessation Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months. You can progress at your own pace without pressure.

Please call to begin your program or to request further information. You may also contact your Human Resources Department for an informational brochure.

## Care Support

This program focuses on disease management for individuals at all health risk levels. The program is voluntary and is customized to meet your individual unique needs. If you qualify for the program you will automatically receive a welcome letter and educational materials in the mail, followed by your first welcome call from the nurse. Future phone calls and personal counseling are provided according to your condition and level of severity. The program also offers preventive care reminders, educational materials and special web resources.

You may choose not to participate at any time by calling the care support center and talking to the program coordinators. If you are invited to participate in the program, or think you are eligible and have not been invited, you may call toll-free at 1-888-264-1744.

# COVERAGE INFORMATION

## ***Choosing A Health Care Provider***

You may choose any eligible provider of health services for the care you need. The Plan may pay higher benefits if you choose In-Network Providers.

### **In-Network Providers**

When you choose these providers, you get the most benefits for the least expense and paperwork. These providers will take care of any notification requirements and send your claims to the Claims Administrator and the Claims Administrator sends payment to the provider for covered services you receive. The provider directory lists In-Network Providers and may change as providers enroll or terminate their agreements. For a complete list of In-Network Providers refer to the Claims Administrator's website. For benefit information on these providers, refer to the Benefit Chart.

### **Out-of-Network Providers**

Nonparticipating Providers may not take care of notification requirements or file claims for you. You may also pay more of the bill. Refer to the next section for a description of charges that are your responsibility.

## ***Continuity of Care***

### **Continuity of Care for New Members**

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

Continuation for up to 120 days:

1. An acute condition;
2. A life-threatening mental or physical illness;
3. A physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
4. A disabling or chronic condition in an acute phase or that is expected to last permanently;
5. You are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. You are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery):

1. A pregnancy beyond the first trimester.

## **Transition to Participating Providers**

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

## **Continuity of Care for Current Members**

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

Continuation for up to 120 days:

1. An acute condition;
2. A life-threatening mental or physical illness;
3. A physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
4. A disabling or chronic condition in an acute phase or that is expected to last permanently;
5. You are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. You are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery):

1. A pregnancy beyond the first trimester.

## **Transition to Participating Providers**

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

## **Termination for Cause**

If the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with or transition of care to that provider. Your transition to a participating provider must occur immediately.

## ***Liability for Health Care Expenses***

### **Charges That Are Your Responsibility**

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

1. deductibles;
2. copays and coinsurance;
3. charges that exceed the benefit maximum;
4. charges for services that are not covered; and
5. charges for services that are investigative or not medically necessary if you are notified in writing before you receive services that the services are not covered and you agree in writing to pay all charges.

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 service agreement with the Claims Administrator, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. You are responsible for payment of any billed charges that exceed the allowed amount. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

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

If you or the provider fail to contact the Claims Administrator for prior authorization or preadmission notification, your benefits may be reduced and you could pay additional charges.

## ***BlueCard Program***

### **Liability Disclosure**

When you obtain health care services through the BlueCard Program outside the geographic area BCBSM serves, the amount you pay for covered services is usually calculated on the **lower** of:

1. The billed charges for your covered services; or
2. The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes on to the Claims Administrator.

Often, this “negotiated price” consists of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, the negotiated price is either 1) an estimated price that factors expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers into the actual price; or 2) billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will be prospectively adjusted to correct for over- or underestimation of past

prices. The amount you pay, however, is considered a final price and will not be affected by the prospective adjustment.

Statutes in a small number of states may require the Host Blue either 1) to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim; or 2) to add a surcharge. If any state statutes mandate liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claims Administrator will calculate your liability for any covered health care services according to the applicable state statute in effect at the time you received your care.

## ***Provider Payment Methods***

### **Withhold and Bonus Payment Disclosure**

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

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 patients. In order to determine quality of care, certain factors are measured, such as 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.

This Plan features a large network of providers. Each provider is an independent contractor and is not the Claims Administrator's agent. The above is a general summary of the Claims Administrator's provider withhold and bonus payment methodology only. While efforts are made to keep this form as up to date as possible, 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 this payment methodology may not apply to your particular plan.

## ***Recommendations by Health Care Providers***

In some cases, your provider may recommend or provide written authorization for services that are specifically excluded by the Plan. When these services are referred or recommended, a written authorization from your provider does not override any specific Plan exclusions.

## ***Fraudulent Practices***

Coverage for you or your dependents will be terminated if you or your dependent: materially misrepresent your medical history on the application for coverage; submit fraudulent, altered, or duplicate billings for personal gain; and/or allow another party not covered under the Plan to use your or your dependent's coverage.

## ***Excessive and Harmful use of Health Care Services***

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

The Claims Administrator will send you a letter giving you 30 days to select one participating physician, one participating hospital, and one participating pharmacy to coordinate all of your health care needs. If you do not make a selection the Claims Administrator will select one 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.

The Claims Administrator 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. and ends at 12:00 a.m. the following day.

### ***Medical Policy Committee***

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

# NOTIFICATION REQUIREMENTS

## ***Prior Authorization***

The Claims Administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. Prior authorization from the Claims Administrator is recommended before you receive selected services so that you avoid incurring charges for services that may not be considered medically necessary. In-Network Providers will obtain prior authorization for you.

**If you are using a provider that does not participate with the Claims Administrator, you are responsible for obtaining prior authorization. The Claims Administrator recommends that you or the provider contact them at least 10 working days prior to receiving the care to determine if the services are eligible.** The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

With prior authorization, the Plan guarantees payment for services approved in advance **if the services are otherwise covered under the Plan** and you are covered on the date you receive care, you have not exceeded your lifetime or benefit maximum, and the procedure that is authorized is the service that is billed by the provider. All applicable preexisting condition limitations, exclusions, deductibles, copays, and coinsurance provisions continue to apply. The prior authorization will indicate a specified time frame in which you may receive the services. Any service not performed in the specific time frame will need to be prior authorized again. You will be responsible for payment of services that the Claims Administrator determines are not medically necessary.

While all services must be medically necessary, prior authorization is recommended for certain services. This list is subject to change due to changes in medical policy. The most current list is available by calling Customer Service.

1. Bariatric surgery
2. Benefit substitution
3. Cosmetic Versus Medically Necessary Procedures-Including but not limited to:
  - a. Blepharoplasty
  - b. Panniculectomy
  - c. Reduction mammoplasty
  - d. Rhinoplasty
  - e. Scar excision/revision
  - f. Mastopexy
4. Coverage of routine care related to cancer clinical trials
5. Dental services that are accident-related for the treatment of injury to sound and healthy natural teeth
6. Drugs – including but not limited to:
  - a. Alefacept (Amevive) and efalizumab (Raptiva)
  - b. Growth hormones
  - c. Injectable fertility medications
  - d. Intravenous immunoglobulin (IVIG) and subcutaneous immunoglobulin
  - e. Leuprolide acetate (Lupron), for all uses except for cancer-related diagnoses

- f. Omalizumab (Xolair) for allergic asthma
- 7. Durable medical equipment (DME) using unlisted codes over \$1,000, and certain supplies or devices- including, but not limited to:
  - a. Neuromuscular electrical stimulation
  - b. Vest percussors
  - c. Wound healing treatment/devices
  - d. Specialty beds, mattresses and overlays
  - e. Hearing devices
- 8. Home health care
- 9. Hospice care
- 10. Home infusion
- 11. Humanitarian use devices (procedures using devices under the FDA category of Humanitarian Device Exemption)
- 12. Hyperhidrosis surgery
- 13. MRI of the Breast
- 14. Orthognathic surgery
- 15. Refractive eye surgery
- 16. Surgical treatment of obstructive sleep apnea and upper airway resistance syndrome
- 17. Temporomandibular joint disorder (TMJ) surgical procedures
- 18. Vagus Nerve Stimulation (for all conditions)
- 19. Transplants:
  - a. Autologous islet cell transplants
  - b. Organ transplant procedures (except kidney)
  - c. Cord Blood, stem cell and bone marrow procedures

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

**The Claims Administrator prefers that all requests for prior authorization for nonparticipating providers be submitted in writing. Please submit your request to the address provided in the Customer Service section.**

### ***Preadmission Notification***

Preadmission notification is required at least five (5) days in advance of being admitted for inpatient care for any type of nonemergency service and for partial hospitalization, day treatment or intensive outpatient treatment for behavioral health conditions. In-Network Providers will provide preadmission notification to the Claims Administrator for you. With preadmission notification, the Plan guarantees payment for days or services the Claims Administrator authorizes if the services are otherwise covered under the Plan, and you are covered on the date you receive the services.

**If you are going to receive nonemergency care from a Nonparticipating Provider, you are responsible for providing preadmission notification to the Claims Administrator.**

If the Claims Administrator is not notified, a penalty will apply. The Claims Administrator reduces the allowed amount for the admission by 25 percent before applying deductibles or copays. This means that without preadmission notification, you will pay a greater portion of the charges. If preadmission notification is not provided and services are later determined not to be medically necessary, you are also responsible for payment of those charges.

Preadmission notification is required for the following facilities:

1. Hospitals
  - a. Acute care admissions
  - b. Rehabilitation admissions
2. Skilled nursing facilities
3. Residential behavioral health treatment facilities
4. Outpatient behavioral health treatment facilities providing partial hospitalization, day treatment or intensive outpatient treatment

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

### ***Emergency Admission Notification***

Notice is required as soon as reasonably possible for admission for pregnancy or for a medical emergency or injury that occurred within 48 hours before admission.

If you have an emergency admission to a Nonparticipating Provider, you or the provider must notify the Claims Administrator as soon as reasonably possible.

The Plan pays only for services the Claims Administrator determines are medically necessary. There is no penalty for failure to notify the Claims Administrator of an emergency admission if the Claims Administrator determines that the admission was medically necessary.

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

# CLAIMS PROCEDURES

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

## ***Types of Claims***

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

### **Pre-service Claim**

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

### **Urgent Care Claim**

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

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

### **Concurrent Care Claim**

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

### **Post-service Claim**

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

## **Change in Claim Type**

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

## ***Filing Claims***

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

### **Urgent Care Claims**

An Urgent Care Claim may be submitted to the Claims Administrator by telephone at (651) 662-5001 or toll free at 1-800-531-6681.

### **Pre-service Claims**

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

### **Post-service Claims**

A Post-service Claim must be filed within 90 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 15 months after the date of receipt of the service, treatment or product to which the claim relates.

### **Incorrectly-Filed Claims**

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

## ***Timeframes for Deciding Claims***

### **Urgent Care Claims**

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

## **Pre-service Claims**

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

## **Concurrent Care Extension Request**

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

## **Concurrent Care Reduction or Early Termination**

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

## **Post-Service Claims**

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

## **Extensions of Time**

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

## ***Incomplete Claims***

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

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

## ***Notification of Initial Benefit Decision***

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide

the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether the decision is adverse or not. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

## ***Appeals of Adverse Benefit Determinations***

### **Appeal Procedures**

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination. The Claims Administrator will follow these procedures when deciding an appeal:

1. A claimant will have at least 180 days following receipt of a notice of an adverse benefit determination within which to appeal the determination;
2. A claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual;
4. The Claims Administrator will give no deference to the initial benefit decision;
5. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
6. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
7. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice; and
8. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator.

### **Filing Appeals**

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

### **Urgent Care Appeals**

An urgent care appeal may be submitted to the Claims Administrator by telephone at (651) 662-5001 or toll free at 1-800-531-6681. The Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

## ***Timeframes for Deciding Appeals***

### **Urgent Care Claims**

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

### **Pre-Service Claims**

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

### **Post-service Claims**

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

### **Concurrent Care Claims**

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

## ***Notification of Appeal Decision***

The Claims Administrator will provide the claimant with written notice of the appeal decision. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. The decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced.**

## ***Voluntary Appeals***

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

## ***Additional Provisions***

### **Authorized Representative**

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

under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

## **Claims Payment**

When a claimant uses In-Network Providers and providers outside Minnesota who participate with other Blue Cross and Blue Shield plans nationwide for covered services, the Plan pays the provider. When a claimant uses a Nonparticipating Provider either inside or outside the State of Minnesota for covered services, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for certain out-of-state institutional and medical/surgical providers.

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

## **Release of Records**

Claimants agree to allow all health care providers to give the Claims Administrator needed information about the care that they provide to them. The Claims Administrator may need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

## **Right of Examination**

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

# BENEFIT CHART

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

## ***Benefit Features, Limitations, and Maximums***

<b>Benefit Features</b>	<b>Your Liability</b>
<b>Copays</b>	
• Transplant specific copay	\$5,000
• Prescription drugs:	
<u>Retail Pharmacy:</u>	
▪ Generic drug copay	\$0
▪ Formulary brand name drug copay	\$20
▪ Nonformulary brand name drug copay	\$30
<u>Mail Services Pharmacy:</u>	
▪ Generic drug copay	\$0
▪ Formulary brand name drug copay	\$40
▪ Nonformulary brand name drug copay	\$60

### **Deductible**

(Deductible carryover applies)

(Does not include prescription drug copays)

- |                          |                                      |
|--------------------------|--------------------------------------|
| • All providers combined | \$500 per person per calendar year   |
|                          | \$1,000 per family per calendar year |

<b>Benefit Features</b>	<b>Limitations and Maximums</b>
<b>Out-of-Pocket Maximums</b>	
• All providers combined	\$1,200 per person per calendar year
(Does not include transplant specific copays or prescription drug copays)	\$2,400 per family per calendar year
• Prescription Drug Out-of-Pocket Maximum	\$500 per person per calendar year
(Does not include drugs used during inpatient admission)	\$750 per family per calendar year

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**Lifetime Maximum**

- Inpatient mental health and substance abuse services 146 days per person.
  - Total benefit paid to all providers combined \$5 million per person
- 

***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
<ul style="list-style-type: none"><li>Air or ground transportation for basic or advanced life support from the place of departure to the nearest facility equipped to treat the illness</li><li>Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse</li></ul>	80% after you pay the deductible.	80% after you pay the deductible.

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**NOTES:**

- Please see the Notification Requirements section.**
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

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**NOT COVERED:**

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

## Behavioral Health Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Outpatient health care professional charges</li> <li>• Outpatient hospital/outpatient behavioral health treatment facility charges</li> </ul> <p>40 hour maximum per person per calendar year for professional and facility charges combined.</p>	<p>First 10 hours: 80% after you pay the deductible.</p> <p>Next 30 hours: 75% after you pay the deductible.</p>	<p>When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.</p>
<ul style="list-style-type: none"> <li>• Inpatient health care professional charges</li> <li>• Inpatient hospital/residential behavioral health treatment facility charges</li> </ul> <p>73 day maximum per person per calendar year.</p> <p>73 day maximum per person per calendar year.</p>	<p>80% after you pay the deductible.</p>	<p>When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Court-ordered treatment for mental health and 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. An initial court-ordered exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator.
- Court-ordered treatment for mental health and 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 part of a recommended treatment plan. For group therapy, two (2) sessions equal one (1) treatment hour.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- Treatment of emotionally handicapped children in a licensed residential treatment facility is covered the same as any other inpatient hospital medical admission.
- There is no coverage for services you receive from a Nonparticipating Provider unless the provider is located outside the State of Minnesota and is a member of the participating network of their local Blue Cross and/or Blue Shield Plan.
- Inpatient substance abuse and mental health services have a combined lifetime maximum benefit of 146 days per person.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include telephone calls or email.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- services for mental illness not listed in the most recent edition of International Classification of Diseases
  - custodial and supportive care
  - court-ordered services that are not medically necessary
  - services for marriage counseling or training services
  - please refer to the General Exclusions section
-

## Behavioral Health Substance Abuse Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Outpatient health care professional charges</li> <li>• Outpatient hospital/outpatient behavioral health treatment facility charges  130 hour maximum per person per calendar year for professional and facility charges combined.</li> <li>• Outpatient hospital/outpatient behavioral health treatment facility charges  130 hour maximum per person per calendar year for professional and facility charges combined.</li> </ul>	80% after you pay the deductible.	When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.
<ul style="list-style-type: none"> <li>• Inpatient health care professional charges  73 day maximum per person per calendar year.</li> <li>• Inpatient hospital/residential behavioral health treatment facility charges  73 day maximum per person per calendar year.</li> </ul>	80% after you pay the deductible.	When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.

**NOTES:**

- **Please see the Notification Requirements section.**
- Court-ordered treatment for mental health and 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. An initial court-ordered exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator.
- Court-ordered treatment for mental health and 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.
- Admissions that qualify as “emergency holds”, as the term is defined in Minnesota Statutes, are considered medically necessary for the entire admission.
- Outpatient family therapy is covered if part of a recommended treatment plan.
- There is no coverage for services you receive from a Nonparticipating Provider unless the provider is located outside the State of Minnesota and is a member of the participating network of their local Blue Cross and/or Blue Shield Plan.
- Inpatient substance abuse and mental health services have a combined lifetime maximum benefit of 146 days per person.

- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include telephone calls or email.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- custodial and supportive care
  - court-ordered services that are not medically necessary
  - please refer to the General Exclusions section
-

## Chiropractic Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"><li>Chiropractic care</li></ul>	80% after you pay the deductible.	80% after you pay the deductible.

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**NOTES:**

- Please see the Notification Requirements section.**
- Chiropractic care is limited to a maximum benefit of \$500 per person per calendar year when you use a Nonparticipating Provider.
- For lab and x-ray services billed by a health care professional, please refer to Physician Services. For lab and x-ray services billed by a facility, please refer to Hospital Inpatient or Hospital Outpatient.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- services primarily educational in nature
  - vocational rehabilitation
  - services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy, 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, massage therapy, etc., and all related material and products for these programs
  - rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time
  - please refer to the General Exclusions section
-

## Dental Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Accident-related dental services from a physician or dentist for the treatment of an injury to sound, natural teeth</li> <li>• Oral surgery and anesthesia for:               <ul style="list-style-type: none"> <li>▪ removal of impacted teeth</li> <li>▪ removal of a tooth root without removal of the whole tooth</li> </ul> </li> <li>• Root canal therapy</li> <li>• Treatment of cleft lip and palate for a dependent child</li> <li>• Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.

**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 must be started within six (6) months of the injury or within six (6) months of your effective date of coverage under this Plan.
- 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 facility charges please refer to Hospital Inpatient or Hospital Outpatient.
- Treatment for cleft lip and palate includes inpatient and outpatient expenses arising from medical and dental treatment, including orthodontia and oral surgery. For medical services please refer to Hospital Inpatient, Hospital Outpatient, Physician Services, etc.
- Treatment for cleft lip and palate is limited to services that are scheduled or initiated prior to the dependent child turning age 19.
- 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.
- Orthognathic surgery is covered for the treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder.
- 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 dental prosthesis.
- A sound natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound natural tooth.
- Dependent child is defined by the age for a dependent child or student dependent child, whichever is later, if applicable, as specified in this Plan.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- dental services to treat an injury from biting or chewing
  - dentures and dental implants, regardless of the cause or the condition, and any associated services and/or charges
  - replacement of a damaged bridge from an accident-related injury
  - osteotomies and other procedures associated with the fitting of dentures or dental implants
  - all orthodontia, except when related to the treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder and for the treatment of cleft lip and palate up to the dependent child age limit
  - tooth extractions, unless otherwise specified as covered
  - accident-related dental services started more than six (6) months after the injury or six (6) months of your effective date of coverage under this Plan
  - any other dental procedure or treatment
  - please refer to the General Exclusions section
-

## Emergency Room

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"><li>• Outpatient hospital/facility charges<ul style="list-style-type: none"><li>▪ emergency room</li></ul></li><li>• Outpatient health care professional charges</li></ul>	80% after you pay the deductible.	80% after you pay the deductible.

---

**NOTES:**

- **Please see the Notification Requirements section.**
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- please refer to the General Exclusions section
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## Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• 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:               <ul style="list-style-type: none"> <li>▪ registered nurse;</li> <li>▪ licensed registered physical therapist;</li> <li>▪ master's level clinical social worker;</li> <li>▪ registered occupational therapist;</li> <li>▪ certified speech and language pathologist;</li> <li>▪ medical technologist; or</li> <li>▪ licensed registered dietician</li> </ul> </li> <li>• 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</li> <li>• Use of appliances that are owned or rented by the home health agency</li> <li>• Home health care following early maternity discharge. See Maternity.</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Coverage is limited to a maximum benefit of 180 visits per person per calendar year.
- One (1) home health care visit consists of up to four (4) consecutive hours in a 24 hour period.
- The one (1) home health care visit following early maternity discharge does not apply to the 180 visit maximum.
- 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.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- custodial or nonskilled care
- services of a nonmedical nature
- please refer to the General Exclusions section

## Home Infusion Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Home infusion therapy services when ordered by a physician</li> <li>• Solutions and pharmaceutical additives, pharmacy compounding and dispensing services</li> <li>• Durable medical equipment</li> <li>• Ancillary medical supplies</li> <li>• Nursing services to:               <ul style="list-style-type: none"> <li>▪ train you or your caregiver; or</li> <li>▪ monitor your home infusion therapy</li> </ul> </li> <li>• Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy</li> <li>• Other eligible home health services and supplies provided during the course of home infusion therapy</li> </ul>	<p>80% after you pay the deductible.</p>	<p>When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- There is no coverage for services you receive from a Nonparticipating Provider unless the provider is located outside the State of Minnesota and is a member of the participating network of their local Blue Cross and/or Blue Shield Plan.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

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

## Hospice Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Hospice care for terminally ill patients provided by a Medicare approved hospice provider or other preapproved hospice</li> <li>• Inpatient and outpatient hospital care, routine and continuous home nursing care, home health aide visits, physical therapy, speech and language therapy, occupational therapy, social worker visits, dietary/nutritional counseling, durable medical equipment, routine medical supplies and other supportive services provided to meet the physical, psychological, spiritual, and social needs of the dying individual</li> <li>• Prescription drugs, in-home lab services, IV therapy, and other supplies related to the terminal illness or injury prescribed by the attending physician or any physician that is part of the hospice care team</li> <li>• Instructions for the care of the dying patient, bereavement counseling, respite care and other supportive services for the family of the dying individual, both before and after the death of the individual</li> </ul>	<p>80% after you pay the deductible.</p>	<p>When you use an Out-of-Network Provider, there is <b>NO COVERAGE</b>.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Medical care services unrelated to the terminal illness may be covered according to other Plan benefits and requirements.
- Services provided by the primary care physician are covered but are separate from the hospice benefit.
- Services provided by a skilled nursing facility are covered but are separate from the hospice benefit.
- 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 illness.
- Benefits are restricted to terminally ill patients with a life expectancy of six (6) months or less. The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- Coverage for respite care is limited to not more than five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- There is no coverage for services you receive from an Out-of-Network Provider.

**NOT COVERED:**

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

## Hospital Inpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Semiprivate room and board and general nursing care (private room is covered only when medically necessary)</li> <li>• Intensive care and other special care units</li> <li>• Operating, recovery, and treatment rooms</li> <li>• Anesthesia</li> <li>• Prescription drugs and supplies used during a covered hospital stay</li> <li>• Lab and x-ray</li> <li>• Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.

**NOTES:**

- **Please see the Notification Requirements section.**
- **For bariatric surgery services, you have the option of using Blue Distinction Centers for Bariatric Surgery<sup>sm</sup>. Call Customer Service or visit the Claims Administrator’s website prior to receiving bariatric surgery services for a list of Blue Distinction Centers for Bariatric Surgery. These facilities have been selected through a rigorous evaluation of clinical data including outcomes of care. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgical care services including inpatient care, post-operative care, follow-up, and patient education.**
- The Plan covers kidney and cornea transplants. For other kinds of transplants, refer to Organ and Bone Marrow 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.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- communication services provided on an outpatient basis or in the home
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- please refer to the General Exclusions section

## Hospital Outpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Scheduled surgery/anesthesia</li> <li>• Radiation and chemotherapy</li> <li>• Kidney dialysis</li> <li>• Respiratory therapy</li> <li>• Physical, occupational, and speech therapy</li> <li>• Lab and x-ray</li> <li>• Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>• All other eligible outpatient hospital care</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**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.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- please refer to the General Exclusions section

## Infertility Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Artificial and intrauterine insemination procedures</li> <li>• Related services and supplies</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.
<ul style="list-style-type: none"> <li>• Injectable drugs administered by a health care professional</li> </ul>	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

**NOTES:**

- **Please see the Notification Requirements section.**
- Benefits for artificial insemination (AI) or intrauterine insemination (IUI) procedures are limited to six (6) cycles per patient per lifetime, or per pregnancy. The six (6)-cycle limit will be renewed if successful pregnancy is attained. Pregnancy must be confirmed by a live birth, an ultrasound, or by a miscarriage documented by a pathology report.
- Benefits for injectable prescription drugs for eligible infertility treatment are limited to six (6) cycles per person per lifetime, or per pregnancy. The six (6)-cycle limit will be renewed if successful pregnancy is attained. Pregnancy must be confirmed by a live birth, an ultrasound, or by a miscarriage documented by a pathology report.
- Any cycle billed to the Claims Administrator using artificial insemination, intrauterine insemination, and/or injectable prescription drugs will be applied to the six (6)-cycle maximum. If the patient abandons a treatment regimen before the cycle is complete, the partial cycle may be counted as one of the six (6) eligible cycles or the patient may assume all charges for that cycle in order to preserve benefits for six (6) complete cycles.
- A cycle is defined as one (1) partial or complete fertilization attempt extending through the implantation phase only.
- Refer to Hospital Inpatient and Hospital Outpatient for facility charges.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- reversal of sterilization
- sperm banking
- donor ova or sperm
- services and prescription drugs for or related to assisted reproductive technology (ART) procedures, except that the Plan does cover artificial and intrauterine insemination procedures
- services and prescription drugs for or related to gender selection services
- please refer to the General Exclusions section

## Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Health care professional services and hospital/facility charges for prenatal care</li> </ul>	100%	100%
<ul style="list-style-type: none"> <li>• Health care professional services for:               <ul style="list-style-type: none"> <li>▪ delivery in a hospital/facility</li> <li>▪ postpartum care</li> </ul> </li> <li>• Hospital/facility charges for inpatient hospital care</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.

**NOTES:**

- **Please see the Notification Requirements section.**
- Please refer to the Eligibility section to determine when baby's coverage will begin.
- Under Federal law, group health plans such as this Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn child's attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable).
- Under Federal law, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay less than the 48 hours (or 96 hours) mentioned above.
- The Plan covers one (1) home health care visit within four (4) days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See Home Health Care.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- health care professional charges for deliveries in the home
- adoption
- surrogate pregnancy
- child-birth classes
- please refer to the General Exclusions section

## Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds</li> <li>• Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings</li> <li>• Insulin pumps, glucometers and related equipment and devices</li> <li>• Blood, blood plasma, and blood clotting factors</li> <li>• Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes</li> <li>• Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician</li> <li>• Corrective lenses for aphakia</li> <li>• Cochlear implants</li> <li>• Scalp hair prosthesis (wigs) provided hair loss is due to alopecia areata. Maximum of \$350 per person per calendar year. Deductible does not apply.</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For coverage of insulin and diabetic supplies, refer to Prescription Drugs and Insulin.
- Rental of an electric breast pump is eligible for coverage only when there is maternal-infant separation due to illness, prematurity, or hospitalization and only for the duration of the separation.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**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
- personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary

- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants
  - modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
  - blood pressure monitoring devices
  - communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
  - eyeglasses, contact lenses, or other optical devices or professional services to fit or supply them, except as provided in this Benefit Chart
  - duplicate equipment, prosthetics, or supplies
  - services for or related to arch supports, orthopedic shoes and foot orthotics, including, but not limited to, such related services as biomechanical evaluation, range of motion measurements and report, and negative foot mold impressions
  - hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment
  - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
  - rental or purchase of a manual breast pump and/or the purchase of an electric breast pump
  - please refer to the General Exclusions section
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## Organ and Bone Marrow Transplant Coverage

The Plan Covers:	Blue Quality Centers for Transplant (BQCT) Providers	Non-Blue Quality Centers for Transplant (BQCT) Providers
<p>The following medically necessary human organ and bone marrow transplant and peripheral stem cell support procedures:</p> <ul style="list-style-type: none"> <li>• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell support procedures</li> <li>• Autologous bone marrow transplant and peripheral stem cell support procedures</li> <li>• Heart, heart-lung, liver (cadaver and living), lung (single or double)</li> <li>• Small-bowel or small-bowel/liver</li> <li>• Pancreas transplant               <ul style="list-style-type: none"> <li>▪ Cadaver – eligible as pancreas transplantation alone (PTA), simultaneous pancreas and kidney transplantation (SPK), or pancreas transplantation after kidney transplantation (PAK), or</li> <li>▪ Living donor segmental pancreas transplantation – eligible alone, at the time of, or following kidney transplantation</li> </ul> </li> </ul>	<p>100% of the Transplant Payment Allowance for the transplant admission.</p> <p>If you live more than 50 miles from a BQCT Provider, there may be benefits available for travel, meals and lodging expenses directly related to a preauthorized transplant. For more information contact the Transplant Coordinator at the number listed below.</p> <p>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.</p>	<p><b>Participating Transplant Provider</b></p> <p>\$5,000 transplant specific copay, then 80% of the Transplant Payment Allowance after you pay the deductible.</p> <p><b>Nonparticipating Transplant Provider</b></p> <p><b>NO COVERAGE.</b></p> <p>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.</p>

**NOTES:**

- **As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions, when appropriate.**
- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for organ and bone marrow transplants. See Hospital Inpatient and Physician Services.
- **Prior authorization is required for all transplant and stem cell support procedures. All requests for prior authorization must be submitted in writing to:**

Blue Cross and Blue Shield of Minnesota  
 Transplant Coordinator  
 P.O. Box 64179  
 St. Paul, Minnesota 55164

If you have specific questions on Organ and Bone Marrow Transplant Coverage, call the Transplant Coordinator of Blue Cross and Blue Shield of Minnesota, Monday through Friday, from 8:00 a.m. to 4:30 p.m. (Central Time) at the Customer Service phone number listed on the back of your health care plan ID card.

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**NOT COVERED:**

- benefits for travel, meals and lodging expenses when you are using a Non-BQCT Provider
  - services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
  - services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
  - services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
  - living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description
  - transplantation of animal organs and/or tissue
  - additional exclusions are listed in the General Exclusions section
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**DEFINITIONS:**

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

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Evaluations/re-evaluations</li> <li>• Office visits from a physical therapist, occupational therapist, speech or language pathologist</li> <li>• Therapies</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.
<ul style="list-style-type: none"> <li>• Office visits from a physician</li> </ul>	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

**NOTES:**

- **Please see the Notification Requirements section.**
- Physical, speech, and occupational therapy services are limited to a combined maximum benefit of \$500 per person per calendar year when you use a Nonparticipating Provider.
- For lab and x-ray services billed by a health care professional, please refer to Physician Services. For lab and x-ray services billed by a facility, please refer to Hospital Inpatient or Hospital Outpatient.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- services primarily educational in nature
- vocational rehabilitation
- services for or related to developmental delay, except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy, 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, massage therapy, etc., and all related material and products for these programs
- learning disabilities and disorders
- rehabilitation services that would not result in measurable progress relative to established goals
- please refer to the General Exclusions section

## Physician Services

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Office visits for illness</li> <li>• Allergy testing, serum, and injections</li> <li>• Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>• Lab and x-ray</li> <li>• Inpatient hospital/facility visits during a covered admission</li> <li>• Outpatient hospital/facility visits</li> <li>• Anesthesia by a provider other than the operating, delivering, or assisting provider</li> <li>• Surgery, including circumcision and sterilization</li> <li>• Assistant surgeon</li> <li>• Bariatric surgery to correct morbid obesity (see NOTES)</li> <li>• Kidney and cornea transplants</li> <li>• Injectable drugs administered by a health care professional</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- **For bariatric surgery services, you have the option of using Blue Distinction Centers for Bariatric Surgery<sup>sm</sup>. Call Customer Service or visit the Claims Administrator's website prior to receiving bariatric surgery services for a list of Blue Distinction Centers for Bariatric Surgery. These facilities have been selected through a rigorous evaluation of clinical data including outcomes of care. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgical care services including inpatient care, post-operative care, follow-up, and patient education.**
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre- and post-operative care.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- If the following services are covered under your Plan, you are entitled to receive care at the In-Network level for the following services from providers who are not affiliated with the Claims Administrator:
  - the voluntary planning of the conception and bearing of children;
  - the diagnosis of infertility;
  - the testing and treatment of a sexually transmitted disease; or
  - the testing of AIDS or other HIV-related conditions.
- The Plan covers certain physician services for preventive care. Refer to Preventive Care.

- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- repair of scars and blemishes on skin surfaces
  - separate charges for pre- and post-operative care for surgery
  - cosmetic surgery to repair a physical defect
  - travel expenses for a kidney donor
  - kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
  - kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
  - please refer to the General Exclusions section
-

## Prescription Drugs and Insulin

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Prescription drugs                             <ul style="list-style-type: none"> <li>▪ insulin</li> <li>▪ drug therapy supplies</li> <li>▪ prescription injectable drugs that are self-administered</li> <li>▪ self-administered contraceptives</li> <li>▪ smoking cessation drugs</li> </ul> </li> </ul>	<p>100% after you pay the prescription drug copay.</p> <p>When you present your ID card or otherwise provide notice of coverage at the time of purchase, you pay only the prescription drug copay.</p> <p>If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, you will be charged the full amount of the prescription drug. You will be reimbursed only the discounted pricing that has been negotiated between the Claims Administrator and the participating pharmacy for that prescription drug less your prescription drug copay. Your out-of-pocket costs may be significantly higher when you do not provide proof of insurance at the time of purchase.</p>	<p>100% after you pay the prescription drug copay, but you must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. You will be reimbursed only the discounted pricing that has been negotiated between the Claims Administrator and a participating pharmacy for that prescription drug less your prescription drug copay.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- A nonformulary copay applies for prescription drugs, insulin and drug therapy supplies not on the Claims Administrator's formulary.
- The Claims Administrator's formulary is a list of brand and generic prescription drugs and drug supplies that are commonly used by patients in an ambulatory care setting. Over-the-counter, injectable medications and drug supplies are not included in this formulary unless they are specifically listed. The Blue Cross Pharmacy and Therapeutics (P&T) Committee is responsible for the selection of this list of products. The formulary is subject to periodic review and modification by this committee.
- You may obtain a 90-day authorized supply of ongoing, long-term prescription medications through the 90dayRX Network which includes participating retail pharmacies and mail order pharmacy for your ongoing, long-term refills. The 90dayRX Network extends the mail order benefit to retail pharmacies participating in the network. You have the option to refill your prescription at a participating 90dayRX Network pharmacy location or through mail service pharmacy. You may contact Customer Service or visit the Claims Administrator's website to locate retail pharmacies participating in the 90dayRX Network or for additional information about mail service pharmacy.
- Prescription drugs and diabetic supplies are covered in a 34-day supply or 100 units, whichever is greater from a retail pharmacy or up to a 90-day supply from a mail service pharmacy. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day.
- Up to 3-cycle supply of self-administered contraceptives may be purchased at a retail pharmacy at one time for one (1) copay, or for one (1) copay per cycle.
- The following diabetic supplies are covered at the same level as prescription drugs when prescribed by a physician: blood/urine testing tabs/strips, needles and syringes, lancets and insulin.
- The Plan will cover prescription smoking cessation products and over-the-counter (OTC) nicotine replacement products with a physician's prescription subject to your copay. Participants in the BluePrint for Health® stop-smoking program may use documented enrollment in place of a physician's prescription for the OTC nicotine replacement products. Some quantity limitation may apply.
- The Plan will cover off label drugs used for cancer treatment as specified by law.

- When identical chemical entities are manufactured by separate companies, the Blue Cross Pharmacy and Therapeutics (P&T) Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
- To locate a participating pharmacy in your area, call the pharmacy information number provided in the Customer Service section.
- For drugs dispensed and used during an admission, see Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, see Medical Equipment, Prosthetics and Supplies.
- A compound drug is a prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution are added to the active ingredient.
- When you pay for the claim in full at the pharmacy or use an Out-of-Network Pharmacy you are required to submit the drug receipt(s) with the claim form for reimbursement.
- You must present your insurance identification card to all providers and pharmacies. If you do not present your identification card, the provider may require payment prior to rendering a service.
- The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. The information on your ID card enables the participating pharmacy to connect electronically with the Claims Administrator to access discounted pricing information. 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 copays and/or deductibles, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.

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**NOT COVERED:**

- charges for giving injections that can be self-administered
  - over-the-counter drugs unless otherwise specified
  - investigative or non-FDA approved drugs
  - vitamin or dietary supplements
  - over-the-counter smoking cessation drugs without a prescription or documented enrollment in the BluePrint for Health® stop-smoking program
  - prescription drugs for or related to infertility treatments, except that the Plan does cover prescriptions for artificial and intrauterine insemination
  - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
  - selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
  - please refer to the General Exclusions section
-

## Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Cancer screening as specified below:               <ul style="list-style-type: none"> <li>▪ Mammograms, one (1) per calendar year</li> <li>▪ Pap smears, one (1) per calendar year</li> <li>▪ Flexible sigmoidoscopies and/or colonoscopies</li> <li>▪ Fecal occult blood testing, one (1) per calendar year</li> <li>▪ Prostate Specific Antigen (PSA) tests, digital rectal exams, one (1) per calendar year</li> <li>▪ Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam) , one (1) per calendar year</li> </ul> </li> <li>• Physical exam</li> <li>• Gynecological exam</li> <li>• Hearing screening, one (1) per calendar year</li> <li>• Vision exam (glaucoma, acuity, and refraction), one (1) per calendar year</li> <li>• Immunizations</li> <li>• Osteoporosis screening (radiology services), one (1) per calendar year</li> <li>• Cholesterol/lipid profile (laboratory services)</li> <li>• Thyroid screening (laboratory services)</li> <li>• Diabetes screening (laboratory services)</li> <li>• Hemoglobin – CBC (laboratory services)</li> <li>• Screening for chlamydia, gonorrhea, and HIV</li> <li>• Hypertension screening</li> </ul>	<p>100%</p>	<p>100%</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Please refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Services performed at a frequency greater than listed above are not covered under the preventive care benefit.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- physicals for research or obtaining licensure, employment, or insurance
  - educational classes or programs
  - eyewear, including lenses, frames, and contact lenses, and fitting, except where eligible under Medical Equipment, Prosthetics, and Supplies
  - please refer to the General Exclusions section
-

## Reconstructive Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part</li> <li>• 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</li> <li>• Treatment of cleft lip and palate for a dependent child</li> <li>• Elimination or maximum feasible treatment of port wine stains</li> </ul>	<p>For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>	<p>For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>

**NOTES:**

- **Please see the Notification Requirements section.**
- Under the Federal Women’s Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Dependent child is defined by the age limit for dependent child or student dependent child, whichever is later, as specified in this Plan.
- 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 dental prosthesis.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- repair of scars and blemishes on skin surfaces
- dentures and dental implants, regardless of the cause or condition, and any associated services and/or charges
- please refer to the General Exclusions section

## Skilled Nursing Facility

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Skilled care ordered by a physician and eligible under Medicare guidelines</li> <li>• Semiprivate room and board</li> <li>• General nursing care</li> <li>• Prescription drugs used during a covered admission</li> <li>• Physical, occupational, and speech therapy</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

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**NOTES:**

- **Please see the Notification Requirements section.**
- You must be admitted within 30 days after hospital admission of at least three (3) consecutive days for the same illness.
- If you are unable to obtain a bed in an In-Network skilled nursing facility within a 50-mile radius of your home due to full capacity, you may be eligible to receive services at an Out-of-Network skilled nursing facility at the In-Network level of coverage.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- custodial or non-skilled care
  - services of a non-medical nature
  - please refer to the General Exclusions section
-

## Well-Child Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"><li>• The following services for a dependent child from birth to age six (6):<ul style="list-style-type: none"><li>▪ preventive services</li><li>▪ developmental assessments</li><li>▪ laboratory services</li><li>▪ immunizations</li></ul></li></ul>	100%	100%

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**NOTES:**

- **Please see the Notification Requirements section.**
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

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**NOT COVERED:**

- please refer to the General Exclusions section
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## BENEFIT SUBSTITUTION

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

1. a care/case management plan is developed in collaboration with the patient and the health care provider prior to the services being provided; and
2. a physician writes an order stating the services to be provided are medically necessary; and
3. the services being provided under the care/case management plan meet the skilled care requirements of the benefit to be used; and
4. the services do not exceed the allowed amount of the benefit being used.

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

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

# GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatments, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by the Claims Administrator in advance of treatment.
3. Charges for or related to care that is custodial or not normally provided as preventive care or treatment of an illness.
4. Services that are normally provided without charge, including services of the clergy.
5. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent and/or child).
6. Services for conditions that are determined to be preexisting conditions in accordance with the terms of the Plan.
7. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while your coverage was in force.
8. Services for dependents if you have employee-only coverage.
9. Services or supplies that are primarily and customarily used for nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants.
10. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.
11. Blood pressure monitoring devices.
12. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
13. Charges for over-the-counter drugs except as specified in the Benefit Chart; vitamin or dietary supplements; and investigative or non-FDA approved drugs.
14. Personal comfort items, such as telephone, television, barber and beauty supplies, guest services, etc.
15. Autopsies.
16. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.
17. Charges made by a health professional for telephone consultations.
18. Charges for furnishing medical records or reports.
19. Charges for failure to keep scheduled visits.
20. Services for or related to treatment of illness or injury which occurs while on military duty that are recognized by the Veteran's Administration as services related to service-connected injuries.
21. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim.

22. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
23. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony.
24. Services that are prohibited by law or regulation.
25. Admission for diagnostic tests that can be performed on an outpatient basis.
26. Services or confinements ordered by a court or law enforcement officer that are not medically necessary. Services that are not considered medically necessary include, but are not limited to the following; custody evaluations, parenting assessment, education classes, classes for Driving Under the Influence (DUI) and/or Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.
27. Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by the Claims Administrator as medically necessary.
28. 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.
29. Services for or related to private-duty nursing, except as specified in the Benefit Chart.
30. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy. Services that do not involve direct patient contact, such as delivery charges and recordkeeping.
31. Charges for giving injections which can be self-administered.
32. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
33. 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, except as specified in the Benefit Chart.
34. Charges for rehabilitation services that would not result in measurable progress relative to established goals.
35. Services for or related to recreational or educational therapy, 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, massage therapy, etc., and all related material and products for these programs.
36. Services for or related to sex transformation/gender reassignment surgery, sex hormones related to the surgery, related preparation and follow-up treatment, or care and counseling.
37. Services and prescription drugs for or related to assisted reproductive technology (ART), except that the Plan does cover artificial and intrauterine insemination procedures.
38. Services for or related to reversal of sterilization.
39. Services for or related to routine physical exams for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such physical examination would normally have been provided in the absence of the third party request.
40. Services for or related to hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustments, except as specified in the Benefit Chart.

41. 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.
42. Services for or related to dental or oral care, treatment, orthodontics, or surgery and any related supplies, anesthesia or facility charges, except as specified in the Benefit Chart.
43. 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.
44. 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.
45. Services for or related to commercial weight loss programs, fees or dues, nutritional supplements, food, vitamins and exercise therapy, and all associated labs, physician visits, and services related to such programs.
46. Treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment. Services for or related to chelation therapy that the Claims Administrator determines is not medically necessary. Services for or related to systemic candidiasis, homeopathy, and/or immunoaugmentative therapy.
47. Services for or related to fetal tissue transplantation.
48. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
49. Services for or related to growth hormone, except that replacement therapy is eligible for conditions that meet medical necessity criteria as determined by the Claims Administrator prior to receipt of the services.
50. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
51. Services for or related to smoking cessation program fees and/or related program supplies, except as specified in the Special Features section.
52. Services which are not within the scope, licensure or certification of a provider.
53. Dentures and dental implants, regardless of the cause or condition, and any associated services and/or charges including bone grafts.

## ***Eligible Employees***

All full time and part time employees working an average of 20 hours per week are eligible.

Retirees must contact the Plan Administrator for eligibility information.

This Plan covers only those employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage.

## ***Eligible Dependents***

1. Spouse, meaning:
  - a. Legally married opposite gender spouse;
  - b. Legally separated opposite gender spouse;
  - c. Legally married same gender spouse to whom the employee is married under state or national law that recognizes same gender marriages;
  - d. Individual joined to the employee through a same gender civil union in a jurisdiction that recognizes civil unions;
  - e. Domestic Partner of the employee. An adult whom the Plan Administrator determines:
    - 1) is in a committed and mutually exclusive relationship, jointly responsible for the domestic partner's welfare and financial obligations; and
    - 2) is at least 18 years of age and unmarried; and
    - 3) resides with the domestic partner in the same principal residence and intends to do so permanently; and
    - 4) is not a blood relative of the domestic partner; and
    - 5) is of the same gender as the other domestic partner; and
    - 6) is mentally competent.
2. Unmarried children of the domestic partner of the employee to age 19.
3. Unmarried children of a legal same gender marriage or a legal same gender civil union to age 19.
4. Unmarried natural-born dependent children to age 19.
5. Unmarried legally adopted children and children placed with you for legal adoption to age 19. 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.
6. Unmarried stepchildren to age 19 who live with you and who are claimed as exemptions on your Federal income tax return.
7. Unmarried legal wards to age 19 who live with you and who are claimed as exemptions on your Federal income tax return.

8. Unmarried grandchildren to age 19 who live with you and who are claimed as exemptions on your Federal income tax return.
9. Unmarried children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.
10. Unmarried dependent children as defined to age 25 if the following apply:
  - a. your dependent child must attend an accredited college, university or trade school on a full-time basis as defined by that educational institution; or
  - b. if dependent child is unable to carry 100% of the full-time course load due to illness, injury or physical or mental disability documented by a physician your dependent will remain eligible if he/she carries at least 60% of the full-time course load.

If your dependent child has not graduated or completed a defined course of study, your student dependent may miss one (1) academic term, as defined below during an academic year and remain eligible as a student dependent. However, if your student dependent does not return to school on a full-time basis immediately following the missed academic term coverage will be terminated at the end of the last month of the missed academic term. The Claims Administrator reserves the right to require a paid fee statement indicating the term and number of credits for verification purposes. For the purposes of this section "academic term" is defined as follows:

- Fall academic term – September 1 through December 31;
- Spring academic term – January 1 through May 31;
- Summer academic term – June 1 through August 31.

Coverage will terminate at the end of the month in which the student dependent child graduates or completes a defined course of study.

11. Unmarried handicapped dependent children who reach the limiting age while covered under this Plan if all of the following apply:
  - a. primarily dependent upon you;
  - b. are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness, or mental disorders;
  - c. for whom application for extended coverage as a handicapped dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and
  - d. must have become handicapped prior to reaching limiting age.

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

### ***Preexisting Condition Limitation for Late Entrants***

A preexisting condition limitation applies to late entrants. A preexisting condition is defined as a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the enrollment date.

For such a condition, benefits for you and your covered dependents will be payable only after a period of 18 consecutive months beginning from the enrollment date. This period will be reduced by any prior continuous

creditable coverage. At your request and with appropriate authorization the Claims Administrator will assist you in obtaining a certificate of creditable coverage from your prior plan.

An existing pregnancy is not considered a preexisting condition.

## ***Effective Date of Coverage***

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

### **Adding New Employees**

1. If the Plan Administrator receives your application within 30 days after you become eligible, coverage for you and your eligible dependents starts on the first of the month following the date of eligibility.
2. If the Plan Administrator receives your application more than 30 days after you become eligible, you and your eligible dependents will be considered a Late Entrant unless you meet the requirements of the special enrollment period. Please see Coverage Effective Date for Late Entrants in this section to determine when coverage will begin.

### **Adding New Dependents**

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

#### **Adding spouse and/or stepchildren**

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

#### **Adding newborns and children placed for adoption**

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

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

#### **Adding handicapped children or handicapped dependents**

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

## **Special Enrollment Periods**

Special enrollment periods are periods when eligible employees or dependents may enroll in the Plan under certain circumstances after they were first eligible for coverage. Special enrollment events are triggered by a loss of other group health plan coverage or by acquiring a new dependent. The request for enrollment must be within 30 days of the special enrollment event.

### **Loss of Coverage**

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

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

Coverage is effective the day after the termination of prior coverage or the date of claim denial due to meeting or exceeding the lifetime limit on all benefits.

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

### **Acquiring a New Dependent**

Eligible employees who are either enrolled or not enrolled in the Plan may enroll themselves and newly acquired dependents for coverage in the Plan as special enrollees. If the employee is eligible under the terms of the Plan and acquires a new dependent, the following individuals are eligible for special enrollment:

1. The employee only may enroll when the employee acquires a new dependent through marriage, birth, adoption, or placement for adoption.
2. The spouse of the employee only may enroll when either the individual becomes the new spouse of the employee, or the individual is the spouse of the employee and a child becomes a dependent through birth, adoption, or placement for adoption.
3. The employee and spouse if, either the employee and spouse become married or the employee and spouse are married and acquire a new dependent through birth, adoption, or placement for adoption.
4. The dependent of an employee only when the dependent becomes a dependent of the employee by marriage, birth adoption, or placement for adoption.
5. The employee and a new dependent when an individual becomes a dependent of the employee by marriage, birth, adoption, or placement for adoption.
6. The employee, spouse, and a new dependent when an individual becomes a dependent of the employee by marriage, birth, adoption, or placement for adoption.

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

Dependent children other than the newly acquired dependent are also eligible for the special enrollment period.

The special enrollment period is also available to the employee or dependent who is requesting enrollment on a contract anniversary, which is scheduled every five (5) years starting on September 1, 2004 and continuing every five (5) years thereafter. The employee or dependent enrolling in the plan would have an effective date of September 1 only. This enrollment period is only open prior to the anniversary, and closes September 1 of the year scheduled for this exception.

### ***Coverage Effective Date for Late Entrants***

Late entrants are subject to a preexisting condition limitation period described in the Preexisting Condition Limitations section. Credit will be given for prior continuous creditable coverage. Coverage for late entrants starts on the first of the month following the day the Plan Administrator receives the application.

# TERMINATION OF COVERAGE

## ***Termination Events***

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Plan terminates.
2. For you and your dependents, the last day of the month during which:
  - a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the Claims Administrator receives full payment when due. If the Claims Administrator terminates coverage for all employees in the Plan for nonpayment of the charges, the Claims Administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
  - b. you are no longer eligible.
  - c. you enter military services for duty lasting more than 31 days.
  - d. you request that coverage be terminated.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month during which the employee and spouse divorce or terminate their same gender marriage or civil union or the domestic partner no longer meets the domestic partner requirements.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
  - a. a covered stepchild is no longer eligible because the employee and spouse divorce.
  - b. a covered dependent is no longer eligible because the employee and the domestic partner terminate their domestic partnership.
  - c. a covered dependent is no longer eligible because the employee and the same gender spouse or civil union spouse terminate their marriage or civil union.
  - d. the dependent child marries or reaches the dependent-child age limit.
  - e. the student dependent child no longer meets the student dependent eligibility requirements.
  - f. the dependent child becomes covered as an employee under any health coverage plan sponsored by the employer.
  - g. the handicapped dependent is no longer eligible.
  - h. the dependent grandchild is no longer eligible.
5. The date charges are incurred that result in payment up to the lifetime maximum.

## ***Retroactive Termination***

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

## ***Certification of Coverage***

When you or your covered dependents terminate coverage under the Plan, a certification of coverage form will be issued to you specifying your coverage dates under the health plan and any waiting periods you were required to satisfy. The certification of coverage form will contain all the necessary information another health plan will need to determine if you have prior continuous coverage that should be credited toward any preexisting condition limitation period. Health plans will require that you submit a copy of this form when you apply for coverage.

The certification of coverage form will be issued to you if you request it before losing coverage or when you terminate coverage with the Plan and, if applicable, at the expiration of any continuation period. The Claims Administrator will also issue the certification of coverage form if you request a copy at any time within the 24 months after your coverage terminates.

## ***Extension of Benefits***

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

## ***Continuation and Conversion***

You or your covered dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. You and your eligible dependents must be covered under this Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

### **Qualifying Events**

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

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment).

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

- The death of the **employee**.
- A termination of the **employee's** employment (for reasons other than gross misconduct) or reduction in the **employee's** hours of employment with the employer.
- Entering of decree in the event of a divorce from the **employee**. (Also, if the **employee** eliminates coverage for his or her **spouse** in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the **ex-spouse** lost coverage earlier. If the **ex-spouse** notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce.)
- The **employee** becomes enrolled in Medicare.

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

- The death of the **employee**.
- The termination of the **employee's** employment (for reasons other than gross misconduct) or reduction in the **employee's** hours of employment with the employer.
- Parents' divorce.
- The **employee** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under the Plan.

## Your Notice Obligations

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

- Divorce.
- A dependent child no longer meets the Plan's eligibility requirements.

**Note:** Refer to Disability Extensions in Extension of Maximum Coverage Periods below for three (3) additional notification requirements.

If you or your dependents fail to provide this notice during this 60-day notice period, any dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your dependents will be required to reimburse the Plan for any claims paid.

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

## Employer's and Plan Administrator's Notice Obligations

The employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the **employee**. This 30-day notice to the Plan Administrator is not often used because usually the Plan Administrator is the **employer**. After plan administrators are put on notice of the qualifying event, they have 14 days to send the qualifying event notice. The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later.

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

## Election Procedures

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

You or your dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may

not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor dependent child eligible for coverage. In addition, a dependent may elect continuation coverage even if the covered **employee** does not elect continuation coverage.

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

## How to Elect

Contact the employer to determine how to elect continuation coverage.

## Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you or your dependent had on the day before the qualifying event. Therefore, anyone who is not covered under the Plan on the day before the qualifying event generally is not entitled to continuation coverage. (Exceptions: 1) If coverage was eliminated in anticipation of a qualifying event such as divorce and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse had lost coverage earlier. The ex-spouse must notify the employer within 60 days after the later divorce and establish that the coverage was eliminated earlier in anticipation of divorce; and 2) A child born to or placed for adoption with the covered **employee** during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.)

Qualified beneficiaries must be provided the same rights and benefits as similarly situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly situated active employees or their dependents, then continuation coverage will be modified in the same way. (Examples: 1) If the employer offers an open enrollment period that allows active employees to switch between plans without being considered late entrants, all qualified beneficiaries on continuation should be 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 should also be afforded this same right.)

## Maximum Coverage Periods

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

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

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

## Extension of Maximum Coverage Periods

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

- **Extended Notice Rule:** This extension is applicable only when loss of coverage is due to termination of employment, reduction of hours, death of the **employee**, or the **employee's** Medicare enrollment, and the extension applies to all qualified beneficiaries.

The general rule is that the maximum coverage period runs from the date of the triggering (qualifying) event, even if the actual loss of coverage per the terms of the Plan does not occur until later. The employer has 30 days from the date of the triggering event to notify the Plan Administrator of the qualifying event.

Under the Extended Notice Rule, the maximum coverage period runs from the date that a qualified beneficiary's loss of coverage occurs (rather than the triggering event), if the employer also sends its notice of the qualifying event to the Plan Administrator within 30 days after the loss of coverage instead of 30 days after the occurrence of the triggering event. Use of this delayed commencement of coverage period coupled with the extension of the employer's notice period has the effect of extending the maximum coverage period. (Example: The triggering event, termination of employment, occurs on January 5. The loss of coverage under the terms of the Plan, however, does not occur until January 31. Under the Extended Notice Rule, the employer must notify the Plan Administrator of the qualifying event within 30 days after coverage is lost and the maximum coverage period begins when coverage is lost, January 31.)

- **Disability Extension:** This extension is applicable when the qualifying event is the **employee's** termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration 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 Social Security Administration disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the qualifying event (the **employee's** termination of employment or reduction of hours); 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

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

**Notice Obligation:** If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration 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 qualifying event is the **employee's** termination of employment or reduction of hours (each of which triggers an 18-month maximum coverage period) is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the **employee**, divorce, the **employee** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the **employee's** dependents that are qualified beneficiaries.

If a second qualifying event occurs within an 18-month or 29-month coverage period that gives rise to a 36-month maximum coverage period for the dependent, then the maximum coverage period (for the dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of continuation coverage will occur.

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

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

of employment or reduction of hours is May 15. The **employee** is entitled to 18 months of continuation from the date coverage is lost. The **employee's** dependents are entitled to 36 months of continuation from the date the **employee** is enrolled in Medicare.)

If the qualifying event (**employee's** termination of employment or reduction of hours) is more than 18 months after Medicare enrollment, is the same day as the Medicare enrollment or occurs before Medicare enrollment, no extension is available.

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

### **Termination of Continuation Coverage Before the End of Maximum Coverage Period**

Continuation coverage of the **employee** and dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due. Charges for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a disability, the charges for continuation can be up to the group rate plus a 50% administration fee for months 19-29. All charges are paid directly to the employer.
- After electing continuation, you or your dependents become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable preexisting condition exclusions or limitations, then your continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (**Note:** An exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the new group health plan.)
- You or your dependent became entitled to a 29-month maximum coverage period due to the disability of a qualified beneficiary, but then the Social Security Administration makes the final determination that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered **employees** or their dependents who have coverage under the Plan for a reason other than the continuation coverage requirements of federal law.
- Voluntarily dropping your continuation coverage.

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

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

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

## **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 will apply to those who have elected continuation. Except for certain children described above, dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as dependents.

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

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

## **Special Second Election Period**

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

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

## **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

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

## **Additional Events**

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 charges to your employer in the manner required by your employer. Coverage may be continued for six (6) months after the end of the Plan month during which the temporary leave began.

## **Questions**

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

## Overview

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

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
<ul style="list-style-type: none"> <li>Employment ends (for reasons other than gross misconduct)</li> <li>Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment)</li> </ul>	Employee and dependents	Earlier of: 18 months; or Enrollment date in other group coverage.
<ul style="list-style-type: none"> <li>Divorce</li> </ul>	Former spouse and any dependent children who lose coverage	Earliest of: 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> <li>Death of employee</li> </ul>	Surviving spouse and dependent children	Earliest of: 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end if the employee had lived.
<ul style="list-style-type: none"> <li>Dependent child loses eligibility</li> </ul>	Dependent child	Earliest of: 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> <li>Dependents lose eligibility due to the employee's enrollment in Medicare</li> </ul>	All dependents	Earliest of: 36 months; or Enrollment date in other group coverage; or Date coverage would otherwise end.
<ul style="list-style-type: none"> <li>Retirees of the employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)</li> </ul>	Retiree  Dependents	Lifetime continuation  Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
<b>Extensions to 18-month maximum continuation period:</b> <ul style="list-style-type: none"> <li>Disability, as determined by the Social Security Administration, of employee or dependent(s)</li> </ul>	Disabled individual and all other covered family members	Earliest of: 29 months after the employee leaves employment; or Date disability ends; or Date coverage would otherwise end.

## **Conversion**

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

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

If your coverage ends because you become ineligible or leave the Plan, you must apply for conversion coverage within 63 days after your coverage (or continuation) ends. If your coverage ends because the Plan ends, you must apply for conversion coverage within 63 days after receiving notice of cancellation of the Plan.

Conversion coverage and charges will not be the same as the Plan. Evidence of good health is not required. Regardless of the reason coverage ends, you are not eligible for conversion if you do not apply within 63 days of losing group coverage.

# COORDINATION OF BENEFITS

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

## ***Definitions***

These definitions apply only to this section.

1. The term “plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
  - a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage
  - b. coverage under a government plan or required or provided by law
  - c. individual coverage. Group coverage is always primary and pays first.

Therefore, “plan” does not include:

- a. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time); or
- b. any benefits that, by law, are excess to any private or other nongovernmental program.

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

2. The term “This Plan” means the part of the Plan document that provides health care benefits.
3. “Primary Plan/Secondary Plan” is determined by the Order of Benefits Rules.

When This Plan is a Primary Plan, its benefits are determined before any other plan and without considering the other plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits. Note if you are covered under This Plan and Medicare: This Plan will comply with Medicare Secondary Payor (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a primary Plan and which is a Secondary Plan. Medicare will be primary and This Plan will be secondary only to the extent permitted by MSP rules.

When you are covered under more than two (2) plans, This Plan may be a Primary Plan to some plans, and may be a Secondary Plan to other plans.

4. “Allowable expense” means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. “Allowable expense” does not include an item or expense that exceeds benefits that are limited by statute or This Plan.

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

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

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

## ***Order of Benefits Rules***

1. General: When a claim is filed under This Plan and another plan, This Plan is a Secondary Plan and determines benefits after the other plan, unless:
  - a. the other plan has rules coordinating its benefits with This Plan's benefits; and
  - b. the other plan's rules and This Plan's rules, in part 2. below, require This Plan to determine benefits before the other plan.
2. Rules: This Plan determines benefits using the first of the following rules that applies:
  - a. Nondependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
  - b. Dependent child of parents not separated or divorced: When This Plan and another plan cover the same child as a dependent of different persons, called "parents":
    - 1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
    - 2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

- c. Dependent child of parents divorced or separated or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Plan determines benefits in this order:
  - 1) first, the plan of the parent with physical custody of the child;
  - 2) then, the plan that covers the spouse of the parent with physical custody of the child;
  - 3) finally, the plan that covers the parent not having physical custody of the child; or
  - 4) in the case of joint physical custody, b. above applies.

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

- d. Active/inactive employee: The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
- e. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

## ***Effect on Benefits of This Plan***

1. When this section applies: When the Order of Benefits Rules above require This Plan to be a Secondary Plan, this part applies. Benefits of This Plan may be reduced.
2. Reduction in This Plan's benefits

When the sum of:

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

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

## ***Right to Receive and Release Needed Information***

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

## ***Facility of Payment***

A payment made under another plan may include an amount that should have been paid under This Plan. If this happens, This Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## ***Right of Recovery***

If This Plan pays more than it should have paid under these coordination of benefit rules, This Plan may recover the excess from any of the following:

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

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

# REIMBURSEMENT AND SUBROGATION

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

## The Plan's Right of Subrogation

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

## Obligation to Reimburse the Plan

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

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

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

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

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

## Duty to Cooperate

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

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

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

1. agree to any settlement or compromise of such claims; or
2. bring a legal action against any other party.

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

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

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

### **Attorneys' Fees and Other Expenses You Incur**

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

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

### **What May Happen to Your Future Benefits**

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

### **Interpretation**

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

# GENERAL PROVISIONS

## ***Plan Administration***

### **Plan Administrator**

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

### **Powers and Duties of the Plan Administrator**

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

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

### **Actions of the Plan Administrator**

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

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

### **Nondiscrimination**

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

## ***Termination or Changes to the Plan***

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

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

## ***Funding***

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

## ***Controlling Law***

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

## ***Privacy of Protected Health Information***

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

### **Restrictions on the Use and Disclosure of Protected Health Information**

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

### **Separation Between the Employer and the Plan**

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI:

- Benefits Administrator

This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

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

## ***Employee Retirement Income Security Act (ERISA) Statement of Rights***

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

### **Receive Information About Your Plan and Benefits**

- a. Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

- a. Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.
- b. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

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

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

### **Assistance with Your Questions**

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

## ***Important Plan Information***

Plan Name:	St. Olaf College Comprehensive Major Medical Health Care Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
Plan's Year:	September 1 through August 31 (fiscal year)
Plan Number:	
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution toward the cost of coverage under the Plan will be determined by the Employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.
Type of Plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the Plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor:	St. Olaf College 1520 St. Olaf Avenue Northfield, MN 55057 (507) 646-3068
Plan Sponsor's Employer Identification Number:	41-0693979
Plan Administrator:	St. Olaf College 1520 St. Olaf Avenue Northfield, MN 55057 (507) 646-3068
Named Fiduciary for Claims Purposes:	BCBSM
Named Fiduciary for all other Purposes:	St. Olaf College 1520 St. Olaf Avenue Northfield, MN 55057 (507) 646-3068

Agent for Services of Legal Process:

Director of Human Resources  
St. Olaf College  
1520 St. Olaf Avenue  
Northfield, MN 55057  
(507) 646-3068

Service of legal process may also be made on the  
Plan Administrator.

Plan Document:

The Plan and its attachments constitute the written  
plan document required by ERISA §402.

## DEFINITIONS

<b>Admission</b>	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
<b>Advanced practice nurses</b>	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.).
<b>Allowed amount</b>	<p>The amount that payment is based on for a given covered service of 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 noted in the Benefit Chart.</p> <p>For In-Network Providers, the allowed amount is the negotiated amount of payment that the In-Network Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at In-Network Providers as a result of expected settlements or other factors. The negotiated amount of payment with In-Network Providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per-service allowed amount for such covered services. Through settlements, rebates, and other methods, the Claims Administrator may subsequently adjust the amount due to an In-Network Provider. These subsequent adjustments will not impact or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Claims Administrator or the Plan Administrator, and the percentage of the allowed amount paid by the Claims Administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Claims Administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.</p> <p>For Nonparticipating Providers, the allowed amount is the lesser of billed charge or a percentage of what the Plan would pay an In-Network Provider for the same or similar services.</p>
<b>Assisted Reproductive Technology (ART)</b>	Any treatment or procedures employed to bring about conception without sexual intercourse.
<b>Attending health care professional</b>	A health care professional with primary responsibility for the care provided to a sick or injured person.
<b>Average semiprivate room rate</b>	The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

<b>Blue Distinction Centers for Bariatric Surgery</b>	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.
<b>BlueCard Program</b>	A national Blue Cross and Blue Shield program in which you can receive health plan benefits while traveling or living outside of your service area. You must use Participating Providers and show your membership ID to secure BlueCard Program benefits.
<b>Calendar year</b>	The period starting on January 1st of each year and ending at midnight December 31st of that year.
<b>Care/case management plan</b>	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.
<b>Claims Administrator</b>	Blue Cross and Blue Shield of Minnesota
<b>Coinsurance</b>	<p>The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket maximum. For covered services from In-Network Providers, coinsurance is calculated based on the lesser of the allowed amount or the In-Network Provider's billed charge. Because payment amounts are negotiated with In-Network Providers to achieve overall lower costs, the allowed amount for In-Network Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for In-Network Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage.</p> <p>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.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.</p> <p>Coinsurance Example:</p> <p>You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work</p>

for a typical claim:

For instance, when the Claims Administrator pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over the Claims Administrator's allowed amount when a Nonparticipating Provider is used. For example, if a Nonparticipating Provider ordinarily charges \$100 for a service, but the Claims Administrator's allowed amount is \$95, the Claims Administrator will pay 80% of the allowed amount (\$76). You must pay the 20% coinsurance on the Claims Administrator's allowed amount (\$19), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$24.

Remember, if In-Network Providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Claims Administrator's allowed amount. If Nonparticipating Providers are used, your out-of-pocket costs will be higher as shown in the example above.

<b>Compound drug</b>	A prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution are added to the active ingredient.
<b>Comprehensive pain management program</b>	A multidisciplinary program including, at a minimum, the following components: <ol style="list-style-type: none"><li>1. A comprehensive physical and psychological evaluation;</li><li>2. Physical/occupation therapies;</li><li>3. A multidisciplinary treatment plan; and</li><li>4. A method to report clinical outcomes.</li></ol>
<b>Continuous coverage</b>	The maintenance of continuous and uninterrupted creditable coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the individual applies for coverage within 63 days of the termination of his or her qualifying coverage.
<b>Copay</b>	The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays.  A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.
<b>Cosmetic services</b>	Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.
<b>Covered services</b>	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.
<b>Custodial care</b>	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.

<b>Deductible</b>	<p>The amount you must pay toward the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each person and family are shown on the Benefit Chart.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.</p>
<b>Deductible carryover</b>	<p>The amount applied toward your deductible, under this Plan, during the last three (3) months of the calendar year that the Claims Administrator applies toward your deductible under this Plan, for the next calendar year. This amount will not be applied to the out-of-pocket maximum for the next calendar year.</p>
<b>Drug therapy supply</b>	<p>A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.</p>
<b>Durable medical equipment</b>	<p>Medical equipment prescribed by a physician that meets each of the following requirements:</p> <ol style="list-style-type: none"> <li>1. able to withstand repeated use;</li> <li>2. used primarily for a medical purpose;</li> <li>3. generally not useful in the absence of illness or injury;</li> <li>4. determined to be reasonable and necessary; and</li> <li>5. represents the most cost-effective alternative.</li> </ol>
<b>Enrollment date</b>	<p>The first day of coverage, or if there has been a waiting period, the first day of the waiting period (typically the date employment begins).</p>
<b>Facility</b>	<p>A hospital, home health agency, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment 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 facility.</p>
<b>Foot orthotic</b>	<p>A rigid or semi-rigid orthopedic appliance or apparatus worn to support, align, and/or correct deformities of the lower extremity.</p>
<b>Formulary</b>	<p>The Claims Administrator's formulary is a list of brand and generic prescription drugs and drug supplies that are commonly used by patients in an ambulatory care setting. Over-the-counter, injectable medications and drug supplies are not included in this formulary unless they are specifically listed. The Blue Cross Pharmacy and Therapeutics (P&amp;T) Committee is responsible for the selection of this list of products. The formulary is subject to periodic review and modification by this committee.</p>
<b>Freestanding ambulatory center</b>	<p>A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory center is not part of a hospital, a clinic, a doctor's office, or other health care professional's office.</p>

<b>Health care professional</b>	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, and licensed registered dietitians. Health care professional also includes supervised employees of: Rule 29 behavioral health treatment facility licensed by the Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
<b>Home health agency</b>	A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.
<b>Hospice care</b>	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.
<b>Hospital</b>	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.
<b>Illness</b>	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
<b>In-Network Provider</b>	A provider that has entered into a service agreement with the Claims Administrator. In-Network Providers are also known as Participating Providers.
<b>Investigative</b>	<p>A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:</p> <ol style="list-style-type: none"> <li>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;</li> <li>2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients);</li> <li>3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.</li> </ol> <p>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,</p>

and professional expert consensus opinions of local and national health care providers.

**Late entrant**

An eligible employee or dependent who requests enrollment under the Plan following the enrollment period after which the individual first became eligible for coverage. Late entrants will be subject to a preexisting condition limitation period, with credit for prior continuous creditable coverage.

An individual will not be considered a late entrant if:

1. the individual was covered under creditable coverage at the time the individual was eligible to enroll for coverage under this Plan, declined enrollment on that basis, and presents to the Claims Administrator a certificate of termination of the qualifying coverage within 30 days;
2. the individual is applying for coverage within 30 days of the exhaustion of the maximum continuation period provided by state and federal law;
3. the individual is applying for coverage within 30 days of losing eligibility under other creditable coverage due to a divorce, legal separation, death, termination of employment, reduction in hours, or employer contributions toward the coverage was terminated;
4. the individual is a new spouse of an eligible employee applying for coverage within 30 days of becoming legally married;
5. the individual is a new dependent of an eligible employee for whom coverage is being requested within 30 days of becoming a new dependent;
6. the individual elects a different plan during an open enrollment period; or
7. the coverage being requested is the result of a court order for the addition of a dependent of an eligible employee within 30 days of the issuance of the order.

**Lifetime maximum**

The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent's lifetime under all health plans sponsored by the Plan Administrator. The lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copays, penalties, and other amounts. Refer to the Benefit Chart for specific dollar maximums on certain services.

**Mail service pharmacy**

A pharmacy that dispenses prescription drugs through the U.S. Mail.

**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**

Eligible medical and hospital services that the Claims Administrator determines are appropriate and necessary based on its internal standards. In disputed cases, the standard peer review process is used.

For purposes of mental health care services, the following medically necessary definition applies:

Health care services must be appropriate in terms of type, frequency, level, setting, and duration to the individual's diagnosis or condition, diagnostic testing, and preventive services. Medically necessary care must:

1. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the conditions, procedures, or treatment at issue; and
2. help restore or maintain the individual's health; or

3. prevent deterioration of the individual's condition; or
4. prevent the reasonable likely onset of a health problem or detect an incipient problem.

**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 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, and/or addictions.

**Mental illness**

A mental disorder as defined in the International Classification of Diseases. It does not include alcohol or drug dependence, nondependent abuse of drugs, or mental retardation.

**Nonparticipating Provider**

A provider that has not entered into a service agreement with the local Blue Cross and/or Blue Shield Plan or its subsidiaries.

**Out-of-Network Provider**

A provider that is not considered In-Network for the service being provided. Out-of-Network Providers are also referred to as Nonparticipating Providers.

**Out-of-pocket maximum**

The most each person must pay each year toward the allowed amount for covered services. The following items are applied to the out-of-pocket maximum:

1. Coinsurance
2. Deductible
3. Copays

After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the year. The Benefit Chart lists the out-of-pocket maximum amounts.

Prescription drug copays do not apply to the out-of-pocket maximum, except those dispensed and used during an inpatient admission.

Transplant specific copays do not apply to the out-of-pocket maximum.

**Outpatient Behavioral Health Treatment Facility**

A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

**Outpatient care**

Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

<b>Participating Pharmacy</b>	A nationwide pharmaceutical provider that participates in a network for the dispensing of prescription drugs.
<b>Participating Provider</b>	A provider that has entered into a service agreement with the local Blue Cross and/or Blue Shield Plan.
<b>Physician</b>	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.
<b>Plan</b>	The plan of benefits established by the Plan Administrator.
<b>Preexisting condition</b>	A condition the Claims Administrator has determined existed within a specified time period preceding the enrollment date of your coverage. Conditions are considered to be preexisting if medical advice, diagnosis, care, or treatment was recommended or received.
<b>Preexisting condition limitation period</b>	The time frame based on the enrollment date of your coverage for which services for preexisting conditions will not be covered services under the Plan. This limitation period will be reduced by any prior continuous creditable coverage.
<b>Prescription drug out-of-pocket maximum</b>	The most you must pay toward the allowed amount for prescription drugs per calendar year. After you reach the prescription drug out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for the rest of the year. The Benefit Chart lists the prescription drug out-of-pocket maximum amount.
<b>Prescription drugs</b>	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.
<b>Provider</b>	A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which services are rendered, to provide the health services billed by that provider. Provider also includes home infusion therapy providers, pharmacies, medical supply companies, freestanding ambulatory centers, independent laboratories and ambulances.
<b>Qualifying creditable coverage</b>	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, General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan, the State Children's Health Insurance Program (SCHIP), or any plan similar to any of the above plans provided in this state or in another state as determined by the Commissioner of Commerce or Health.

<b>Residential Behavioral Health Treatment Facility</b>	A facility that provides treatment, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse or 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.
<b>Respite care</b>	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
<b>Retail pharmacy</b>	Any licensed pharmacy that you can physically enter to obtain a prescription drug.
<b>Skilled care</b>	Services that are medically necessary and must be provided by licensed registered nurses or other eligible providers. A service performed by, or under the direct supervision of, a licensed registered nurse or other eligible provider is not considered skilled care if the service can be safely and effectively self-administered or performed by a layperson.
<b>Skilled nursing facility</b>	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.
<b>Smoking cessation drugs</b>	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
<b>Substance abuse and/or addictions</b>	Alcohol, drug dependence or other addictions as defined in the most current edition of the International Classification of Diseases.
<b>Supervised employees</b>	Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or a Rule 29 clinic. 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.
<b>Supply</b>	<p>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.</p> <p>Supplies do not include such things as:</p> <ol style="list-style-type: none"> <li>1. alcohol swabs;</li> <li>2. cotton balls;</li> <li>3. incontinence liners/pads;</li> <li>4. Q-tips;</li> <li>5. adhesives; or</li> <li>6. informational materials.</li> </ol>
<b>Terminally ill patient</b>	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
<b>Treatment</b>	The management and care of a patient for the purpose of combating an illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.

**Waiting period**

The period of time that must pass before you or your dependents are eligible for coverage under the health plan.

**Year**

January 1st through December 31st.

