For Faculty and Staff of:

(herein called the Plan Administrator or the Employer)

PREFERRED PROVIDER ORGANIZATION (PPO) HEALTH CARE PLAN

SILVER PLAN

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

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

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

2. **Blue Cross has determined that the prescription drug coverage offered through your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.**

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year between November 15th and December 31st.
However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage may be affected. Please contact your employer's human resources department for more information.

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

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

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

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

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

Contact Customer Service using the telephone number listed in the "Customer Service" section. You will receive this notice each year. You also may request a copy should you need it at a later date.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the

handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

RIGHTS AND RESPONSIBILITIES

You Have The Right Under This Plan:

- To be treated with respect, dignity and privacy.
- To receive quality health care that is friendly and timely.
- To have 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 have 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.

You Have The Responsibility 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 University of St. Thomas Preferred Provider Organization (PPO) Health Care Plan for benefits effective January 1, 2009.

Coverage under this Plan for eligible faculty, staff, 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 Faculty/Staff-only coverage.

This Plan, financed and administered by University of St. Thomas, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (BCBSM) is the Claims Administrator and provides administrative services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity.

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

Providers are designated as BlueCard PPO or Out-of-Network Providers. This designation is determined by service agreements with the Blue Cross and/or Blue Shield Plan(s) in the state in which services are rendered. (See Choosing A Health Care Provider).

IMPORTANT! When receiving care, present your identification card to the provider who is rendering the services. When receiving services from a BlueCard PPO Provider outside of Minnesota, the PPO suitcase pictured on the front of the identification card allows you the same level of benefits (See Choosing A Health Care Provider) as those received within Minnesota. If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed on the following page.

CUSTOMER SERVICE

Questions?	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for preadmission and emergency admission notification. Monday through Thursday: 7:00 am - 7:00 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) 662-5004 or toll free at 1-866-870-0348
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. For the highest level of benefits you must use a BlueCard PPO Provider.
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.
Prenatal Support Telephone Number	Toll free 1-866-489-6948 or (651) 662-1818 This number is used to enroll in the prenatal support program.
24-Hour Nurse Advice Line 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.
Stop-smoking program	Toll free 1-888-662-BLUE (2583) This number is used to enroll in the stop-smoking program

Prenatal Support

The prenatal support program promotes early, quality prenatal care and provides added support for all members of the expectant family.

To participate in the program, call the prenatal support phone line. A registered nurse will work with you to design a program of risk assessment and education especially for you. The prenatal support nurse will work with you and your physician from that point on to promote a healthy pregnancy. As an added bonus, you will receive a gift if you complete the program.

The prenatal support number is (651) 662-1818 or toll free 1-866-489-6948. Please call this number to enroll in the prenatal support program or to request further information. You may also contact your Human Resources Department for an informational brochure.

24-Hour Nurse Advice Line

The 24-Hour Nurse Advice Line 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 24-Hour Nurse Advice Line telephone number is 1-800-622-9524.

Stop-Smoking

The 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 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.

Dedicated Nurse Support

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

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

Choosing A Health Care Provider

BlueCard PPO Providers

These providers have entered into a service agreement which designates them as a BlueCard PPO Provider with their local Blue Cross and/or Blue Shield Plan. BlueCard PPO Providers are all Participating Providers, but not all Participating Providers are BlueCard PPO Providers. Also, any particular BlueCard PPO Provider's status may change as providers enroll or terminate their agreements. Therefore, it is important that you confirm the provider's status before you receive services. Refer to the Customer Service page for the BlueCard Telephone Number and Website. Use these resources to locate providers and confirm their status as BlueCard PPO Providers. For benefit information on these providers, refer to the Benefit Chart. You must choose BlueCard PPO providers to receive the highest level of benefits for the least out-of-pocket expense. These providers will:

1. accept payment based on the allowed amount;
2. file claims for you; and
3. be paid by their local Blue Cross and/or Blue Shield Plan.

For benefit information on these providers, refer to the Benefit Chart.

Out-of-Network Providers

Out-of-Network Participating Providers

Some states may have providers who have entered into a service agreement with the local Blue Cross and/or Blue Shield Plan, but their agreement does not designate them as a BlueCard PPO Provider. When you choose these providers, benefits will be paid at the Out-of-Network level. Most of these providers will:

1. accept payment based on the allowed amount;
2. file claims for you; and
3. be paid by the local Blue Cross and/or Blue Shield Plan.

For benefit information on these providers, refer to the Benefit Chart.

Out-of-Network Nonparticipating Providers

These providers have not entered into a service agreement with the local Blue Cross and/or Blue Shield Plan. When you choose these providers, you may have substantial out-of-pocket expense. Benefits are paid to you directly and you are responsible for paying the provider. These providers are not obligated to:

1. accept payment based on the allowed amount; or
2. file claims for you

For benefit information on these providers, refer to the Benefit Chart.

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) for a pregnancy beyond the first trimester.

Transition to Participating Providers

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

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) for a pregnancy beyond the first trimester.

Transition to Participating Providers

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

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 BlueCard PPO Providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles;

2. copays and coinsurance;

3. charges that exceed the benefit maximum; and

4. charges for services that are not covered.

When you use Out-of-Network Participating Providers for covered services, payment is still based on the allowed amount. Most Out-of-Network Participating Providers agree to accept the allowed amount as payment in full. If not, you are required to pay all charges that exceed the allowed amount. In addition you are required to pay the following amounts:

1. deductibles;

2. copays and coinsurance;

3. charges that exceed the maximum benefit level; and

4. charges for services that are not covered.

When you use Out-of-Network Nonparticipating Providers for covered services, payment is still based on the allowed amount. However, because an Out-of-Network Nonparticipating Provider had not entered into a service agreement with the local Blue Cross and/or Blue Shield Plan, the Out-of-Network Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use an Out-of-Network Nonparticipating Provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;

2. deductibles;

3. copays and coinsurance;

4. charges that exceed the benefit maximum level; and

5. charges for services that are not covered, including services that the Claims Administrator determines are not covered based on claims coding guidelines.

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 such services. When the Claims Administrator determines that an excessive number of services or prescription drugs are not necessary, the following will occur:

The Claims Administrator will send you a letter giving you 30 days to select one (1) participating physician, one (1) participating hospital, and one (1) 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.

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.

If you receive services from a Minnesota BlueCard PPO Provider prior authorization will be obtained for you. If you receive services from a BlueCard PPO Provider outside the State of Minnesota you will need to check with the provider to determine if prior authorization will be obtained for you. You are responsible for obtaining prior authorization if your provider does not provide this service. **You are responsible for obtaining prior authorization when you are using Out-of-Network Providers.** 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 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.

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

- Bariatric surgery
- Benefit substitution
- Cosmetic versus medically necessary procedures – including, but not limited to: brow ptosis repair; panniculectomy; reduction mammoplasty; rhinoplasty; scar excision/revision; and mastopexy
- Coverage of routine care related to cancer clinical trials
- Dental and oral surgery including, but not limited to: services that are accident-related for the treatment of injury to sound and healthy natural teeth; temporomandibular joint (TMJ) surgical procedures; and orthognathic surgery
- Drugs - including, but not limited to: growth hormones; injectable fertility medications; intravenous immunoglobulin (IVIG); oral fentanyl; subcutaneous immunoglobulin; and rituximab for off-label usage
- Durable Medical Equipment (DME), prosthetics and supplies including but not limited to; unlisted DME codes over $1,000; neuromuscular electrical stimulation; motorized wheelchairs and scooters; vest percussors; specialty beds; mattresses and overlays; wound healing treatment; hearing devices or prosthetics; continuous glucose monitors; and amino acid-based elemental formula
- Home health care
- Hospice care
- Humanitarian and Compassionate use devices (procedures using devices under the FDA category of Humanitarian and Compassionate Use Device Exemption)
- Hyperhidrosis surgery
- Spinal cord stimulators
- Subtalar arthroereisis for treatment of foot disorders
- Surgical treatment of obstructive sleep apnea and upper airway resistance syndrome
- Transplants, except kidney and cornea
- Vagus Nerve Stimulation (for all conditions)

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

The Claims Administrator prefers that all requests for prior authorization 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. 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 receive services from a Minnesota BlueCard PPO Provider preadmission notification will be obtained for you. If you receive services from a BlueCard PPO Provider outside the State of Minnesota you will need to check with the provider to determine if preadmission notification will be obtained for you. You are responsible for obtaining preadmission notification if your provider does not provide this service. **You are responsible for providing preadmission notification to the Claims Administrator when you receive nonemergency care from Out-of-Network Providers.**

If the Claims Administrator is not notified, a penalty will apply. The Claims Administrator reduces the allowed amount for the admission by $200. 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. Residential behavioral health treatment facilities
3. Outpatient behavioral health treatment facilities providing partial hospitalization.

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 receive services from a Minnesota BlueCard PPO Provider emergency admission notification will be obtained for you. If you receive services from a BlueCard PPO Provider outside the State of Minnesota you will need to check with the provider to determine if emergency admission notification will be obtained for you. You are responsible for obtaining emergency admission notification if your provider does not provide this service. **You are responsible for providing emergency admission notification to the Claims Administrator as soon as reasonably possible when you use an Out-of-Network Provider.**

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 BlueCard PPO Providers. These providers will submit claims directly to the local Blue Cross and Blue Shield Plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from Out-of-Network 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) 662-5004 or toll free at 1-866-870-0348.

Pre-service Claims

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

Post-service Claims

A Post-service Claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 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 must file an appeal within 180 days following receipt of a notice of an adverse benefit 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) 662-5004 or toll free at 1-866-870-0348. 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 providers who have signed a BlueCard PPO service agreement with the local Blue Cross and Blue Shield plans, the Plan pays the provider. When a claimant uses an Out-of-Network Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to an Out-of-Network Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay an Out-of-Network Provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for certain institutional and medical/surgical providers outside the State of Minnesota.

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

Release of Records

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

Right of Examination

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

BENEFIT CHART

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

Benefit Features, Limitations, and Maximums

Benefit Features	Your Liability
Copays	
• Transplant specific copay	$5,000
• Prescription drugs:	
Retail pharmacy	
▪ Generic drug copay	$15
▪ Formulary brand name drug copay	$25
▪ Nonformulary brand name drug copay	$50
90dayRx including participating retail 90dayRx pharmacy and mail service pharmacy	
▪ Generic drug copay	$30
▪ Formulary brand name drug copay	$50
▪ Nonformulary brand name drug copay	$100
Deductible	
(Deductible carryover applies. The amount applied toward your deductible under this Plan during the last three (3) months of the calendar year that is applied toward your deductible under this Plan for the next calendar year.)	
(Does not include prescription drug copays)	
• All providers combined	$500 per person per calendar year $1,000 per family per calendar year

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

The following items are applied toward the Out-of-Pocket Maximum:
1. coinsurance;
2. deductibles;
3. copays; and
4. penalties for not giving us preadmission notification.

The following items are NOT applied toward the Out-of-Pocket Maximum:
1. prescription drug copays; and
2. transplant specific copays.

Benefit Features	Limitations and Maximums
Lifetime Maximum	
• Total benefits paid to all providers combined	$3 million per person

Benefit Descriptions

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

Ambulance

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

NOTES:

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

NOT COVERED:

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

Bariatric Surgery

<table>
<tr><th>The Plan Covers:</th><th>Blue Distinction Centers for Bariatric Surgery^{sm}</th><th>Out-of-Network Providers</th></tr>
<tr><td>

- Medically necessary **inpatient hospital/facility** services for bariatric surgery from admission to discharge
  - Semiprivate room and board and general nursing care (private room is covered only when medically necessary)
  - Intensive care and other special care units
  - Operating, recovery, and treatment rooms
  - Anesthesia
  - Prescription drugs and supplies used during a covered hospital stay
  - Lab and x-ray diagnostic imaging
- Medically necessary **outpatient hospital/facility** services for bariatric surgery:
  - Scheduled surgery/anesthesia
  - Lab and x-raydiagnostic imaging
  - All other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery

</td><td>80% after you pay the deductible.</td><td>

Non-Blue Distinction BlueCard PPO Providers:

70% after you pay the deductible.

Nonparticipating Providers:

When you use a Nonparticipating Provider, there is **NO COVERAGE**.

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NOTES:

- **Please see the Notification Requirements section.**
- **As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.**
- **Prior authorization is recommended for bariatric surgery procedures. The Claims Administrator requests prior authorizations be submitted in writing to:**

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

- For a list of Blue Distinction Centers for Bariatric Surgery call Customer Service or visit the Claims Administrator's website.
- For pre and post-operative bariatric services, please refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- For professional services related to eligible bariatric surgery services, please refer to Physician Services.

NOT COVERED:

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

DEFINITIONS:

- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plan's service areas that have been selected after a rigorous evaluation of clinical data that provided 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.
- Out-of-Network Provider for bariatric surgery services means any hospital or other institution that does not have the "Blue Distinction Centers" designation, including providers who have a service agreement with the Claims Administrator or a local Blue Cross and/or Blue Shield plan, and Nonparticipating Providers. Call Customer Service or visit the Claims Administrator's website to verify provider participation status.

Behavioral Health Mental Health Care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ individual/group/family therapy (office/in-home mental health services) ▪ neuro-psychological examinations • Professional health care charges for services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	80% after you pay the deductible.	70% after you pay the deductible.
• Inpatient health care professional charges 85 day maximum per person per calendar year. • Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based Intensive Outpatient Programs (IOP) ▪ all eligible inpatient services ▪ emergency holds 85 day maximum per person per calendar year.	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary.
- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds” as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- Coverage is provided for marriage/couples therapy/counseling.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- Coverage is provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services. For lab and diagnostic imaging billed by a facility, please refer to Hospital Inpatient and Hospital Outpatient.
- For home health related services, please refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone calls, except for eligible E-Visits.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Behavioral Health Substance Abuse Care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ family therapy ▪ opioid treatment • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ Intensive Outpatient Programs (IOP) and related aftercare services	80% after you pay the deductible.	70% after you pay the deductible.
• Inpatient health care professional charges 85 day maximum per person per calendar year. • Inpatient hospital/residential behavioral health treatment facility charges 85 day maximum per person per calendar year.	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Court-ordered treatment for substance abuse care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified substance abuse assessor is deemed medically necessary.
- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator. Court-ordered treatment for substance abuse care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds”, as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services. For lab and diagnostic imaging billed by a facility, please refer to Hospital Inpatient and Hospital Outpatient.
- For home health related services, please refer to Home Health Care.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone calls, except for eligible E-Visits.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Chiropractic Care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Chiropractic care	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Chiropractic care is limited to a maximum of 15 services per person per calendar year when you use an Out-of-Network Provider. Several services may be received during one (1) visit.
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services. For lab and diagnostic imaging services billed by a facility, please refer to Hospital Inpatient or Hospital Outpatient.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Dental Care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Accident-related dental services from a physician or dentist for the treatment of an injury to sound, healthy, natural teeth • Oral surgery and anesthesia for: ▪ removal of impacted teeth ▪ gums and tissues of the mouth when not performed in connection with extraction or repair of teeth • Root canal therapy • Treatment of cleft lip and palate • Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services, treatment and/or restoration of a sound, healthy, natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound, healthy, natural teeth, crowns, fillings and bridges.
- The Plan covers anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- For 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 member 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 dentures or dental prosthesis.

- A sound, healthy, natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound, healthy, natural tooth.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
- dental implants and any associated services and/or charges
- accident-related dental services initiated after 12 months from the date of injury or 12 months of your effective date of coverage under this Plan or occurring more than 24 months after the date of initial treatment
- replacement of a damaged 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
- oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth
- tooth extractions, unless otherwise specified as covered
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section

Emergency Room

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

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, please refer to Hospital Inpatient and Physician Services.
- For urgent care visits, please refer to Hospital Outpatient and Physician Services.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

- please refer to the General Exclusions section

Home Health Care

<table>
<tr><th>The Plan Covers:</th><th>BlueCard PPO Providers</th><th>Out-of-Network Providers</th></tr>
<tr><td>

- Skilled care ordered in writing by a physician and provided by Medicare approved or other preapproved home health agency employees, including, but not limited to:
  - licensed registered nurse;
  - licensed registered physical therapist;
  - master's level clinical social worker;
  - registered occupational therapist;
  - certified speech and language pathologist;
  - medical technologist; or
  - licensed registered dietician
- Services of a home health aide or social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees
- Use of appliances that are owned or rented by the home health agency
- Home health care following early maternity discharge. See Maternity
- Palliative care

</td><td>80% after you pay the deductible.</td><td>70% after you pay the deductible.</td></tr>
</table>

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Home Infusion Therapy

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Home infusion therapy services when ordered by a physician • Solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Durable medical equipment • Ancillary medical supplies • Nursing services to: ▪ train you or your caregiver; or ▪ monitor your home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard Provider to obtain the highest level of coverage.**
- You pay all charges that exceed the allowed amount when you use an Out-of-Network 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:	BlueCard PPO Providers	Out-of-Network Providers
• Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice including: ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Prior approval is recommended for entrance into the hospice benefit, for any inpatient admission while the patient is receiving hospice benefits, for any patient living beyond six (6) months, and for determination of coverage for services unrelated to the terminal condition.
- Benefits are restricted to terminally ill patients with a terminal condition (i.e. life expectancy of six (6) months or less). The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- Inpatient respite care is for the relief of the patient's primary care giver and is limited to a maximum of five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.
- You pay all charges that exceed the allowed amount when you use 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:	BlueCard PPO Providers	Out-of-Network Providers
• Semiprivate room and board and general nursing care (private room is covered only when medically necessary) • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription drugs and supplies used during a covered hospital stay • Lab and diagnostic imaging • Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- The Plan covers kidney and cornea transplants. For other kinds of transplants, refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement
- The Plan covers anesthesia and inpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network 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:	BlueCard PPO Providers	Out-of-Network Providers
• Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational, and speech therapy • Lab and diagnostic imaging • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • All other outpatient hospital care • Urgent care	80% after you pay the deductible.	70% after you pay the deductible.
• Preventive care • Well-child care	100%	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- The Plan covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

- please refer to the General Exclusions section

Maternity

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Health care professional services and hospital/facility charges for prenatal care	100%	70% after you pay the deductible.
• Health care professional services for: ▪ delivery in a hospital/facility ▪ postpartum care • Hospital/facility charges for inpatient hospital care	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- 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 an Out-of-Network Provider.

NOT COVERED:

- health care professional charges for deliveries in the home
- adoption
- services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- childbirth classes
- please refer to the General Exclusions section

Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds • Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings • Insulin pumps, glucometers and related equipment and devices • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years. • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp hair prosthesis (wigs) provided hair loss is due to alopecia areata. Maximum of $350 per person per calendar year. • Foot orthoses when prescribed by a physician or a doctor of Podiatric Medicine.	80% after you pay the deductible.	80% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**

- 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.
- For hearing aid exam services, please refer to Physician Services.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network 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, or as provided in this Benefit Chart
- personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary
- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants
- modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- 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 foot orthoses, including, but not limited to, such related services as biomechanical evaluation, range of motion measurements and report, and negative foot mold impressions, except as provided in this Benefit Chart
- services for or related to hearing aids or devices, and related fitting or adjustment, except as specified in this Benefit Chart
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- please refer to the General Exclusions section

Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Office visits from a physical therapist, occupational therapist, speech or language pathologist • Therapies	80% after you pay the deductible.	70% after you pay the deductible.
• Office visits from a physician	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services.
- For facility charges, please refer to Hospital Inpatient and Hospital Outpatient.
- Office visits include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Physician Services

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Office visit for illness • Office visit for Urgent Care services • E-Visit • Office visit for Retail Health Clinic services • Lab and diagnostic imaging • Allergy testing, serum, and injections • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider (for bariatric surgery, see below) • Surgery, including circumcision and sterilization (for bariatric surgery, see below) • Assistant surgeon (for bariatric surgery, see below) • Kidney and cornea transplants • Injectable drugs administered by a health care professional • Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**

- 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.
- The Plan covers certain physician services for preventive care. Refer to Preventive Care.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the physician's time.
- E-Visit is an on-line evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers hearing aid exams/fittings/adjustments for children age 18 and younger.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Prescription Drugs and Insulin

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescription drugs ▪ insulin ▪ drug therapy supplies ▪ prescription injectable drugs that are self-administered ▪ smoking cessation drugs ▪ amino acid-based elemental formula	100% after you pay the prescription drug copay.	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.
• Eligible over-the-counter (OTC) drugs with a physician's prescription	100%	No Coverage.
• Identified Specialty drugs purchased through a Specialty pharmacy network supplier (see NOTES)	100% after you pay the prescription drug copay.	No Coverage.

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.
- When you present your ID card or otherwise provide notice of coverage at the time of purchase at a participating pharmacy and/or Specialty pharmacy network supplier, you pay only the prescription drug copay.
- 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 provider and/or Specialty pharmacy network supplier 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.
- Specialty drugs are complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are used to treat serious or chronic medical conditions including, but not limited to: fertility, short stature, multiple sclerosis, hemophilia, hepatitis, and rheumatoid arthritis. A current list of identified Specialty prescription drugs and suppliers is available at Claim Administrator's website or by contacting Customer Service. Specialty drugs are not available through 90dayRx.
- You may obtain a 90-day authorized supply of ongoing, long-term prescription medications through a participating 90dayRx retail pharmacy or mail service pharmacy for your ongoing, long-term refills. You have the option to refill your prescription with a 90-day supply at participating 90dayRx retail or mail service pharmacy locations. You may visit www.bluecrossmn.com or contact Customer Service to locate a retail pharmacy participating in the 90dayRx network or Mail Service Pharmacy.
- Prescription drugs and diabetic supplies are covered in a 31-day supply from a retail pharmacy or up to a 90-day supply from a 90dayRx. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day.
- Eligible over-the-counter (OTC) drugs are covered up to a 31-day supply, as an alternative for similar prescription medications, subject to package limitations, at a retail participating pharmacy. OTC drugs are not available through 90dayRx.
- If you choose a brand name drug when the equivalent generic drug is available, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable copay.

- Self-administered injectable and oral prescription drugs for or related to reproduction treatments must be obtained through a Specialty pharmacy network supplier and are subject to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
- The 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 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 including OTC drugs and similar prescription alternatives, are manufactured by separate companies, the Blue Cross Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered. The Blue Cross Coverage Committee is responsible for the final selection of drugs for this list based on recommendations of an independent Pharmacy and Therapeutics (P&T) committee comprised of actively practicing physicians and pharmacists. Decisions to add or remove drugs are based on the medication's safety, efficiency, uniqueness, and cost. OTC drugs and prescription alternatives are eligible for review through the OTC Drug Exception process.
- The Over-the-Counter (OTC) Drug Exception process may apply as follows: if you are prescribed a nonformulary brand name drug that has a covered OTC alternative, that nonformulary brand name drug will be covered at the same level as a nonformulary brand name drug for up to one (1) year if one or more of the following are met and documented by your attending health care professional:
  1. The member has tried and failed at least one (1) OTC and/or generic or formulary brand name alternative in the same therapeutic class for the same diagnosis to be treated with the nonformulary brand name drug;
  2. The OTC and generic or formulary brand name alternative are contraindicated; or
  3. The member has been receiving the nonformulary brand name drug and switching to an OTC drug may cause a health risk.
- 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.

NOT COVERED:

- drugs removed from the formulary for safety reasons may not be covered
- charges for giving injections that can be self-administered
- over-the-counter drugs unless otherwise specified, except as provided in this Benefit Chart
- investigative or non-FDA approved drugs
- vitamin or dietary supplements
- Specialty drugs not purchased through a Specialty pharmacy network supplier
- smoking cessation drugs without a prescription or documented enrollment in the stop-smoking program
- 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:	BlueCard PPO Providers	Out-of-Network Providers
• Cancer screening as specified below: ▪ Mammograms, one (1) per calendar year ▪ Pap smears, one (1) per calendar year ▪ Flexible sigmoidoscopies and/or colonoscopies ▪ Fecal occult blood testing, one (1) per calendar year ▪ Prostate Specific Antigen (PSA) tests, digital rectal exams, one (1) per calendar year ▪ Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam), one (1) each per calendar year • Physical exam • Gynecological exam • Hearing screening, one (1) per calendar year • Vision exam (glaucoma, acuity, and refraction), one (1) per calendar year • Immunizations • Osteoporosis screening (radiology services), one (1) per calendar year • Lab services as specified below: ▪ Cholesterol/lipid profile ▪ Thyroid screening ▪ Diabetes screening ▪ Hemoglobin – CBC ▪ Urinalysis • Screening for chlamydia, gonorrhea, syphilis and HIV • Abdominal Aortic Aneurysm (AAA) screening, one (1) per lifetime	100%	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- 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.
- For services performed at a frequency greater than listed above, please refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- You are entitled to receive care at the In-Network level for the following services if these services are covered under your Plan: screening for sexually transmitted disease or HIV.
- For facility charges, please refer to Hospital Outpatient.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

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:	BlueCard PPO Providers	Out-of-Network Providers
• Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician • Treatment of cleft lip and palate • Elimination or maximum feasible treatment of port wine stains	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- 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.
- Treatment for cleft lip and palate is limited to services that are scheduled or initiated prior to the member turning age 19.
- 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 dentures or dental prosthesis.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Reproduction Treatments

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Professional services for: ▪ Artificial Insemination (AI) and Intrauterine Insemination (IUI) procedures ▪ Non-Investigative Assisted Reproductive Technologies (ART) ▪ Injectable drugs administered by a health care professional for eligible reproduction treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	70% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Outpatient hospital/facility services for: ▪ AI and IUI procedures ▪ Non-Investigative ART ▪ Injectable drugs administered by a health care professional for eligible reproduction treatments • Professional lab services associated with Reproduction Treatments • Hospital/facility lab services associated with Reproduction Treatments • Professional diagnostic imaging services for Reproduction Treatments • Hospital/facility diagnostic imaging services for Reproduction Treatments	80% after you pay the deductible to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.	100% to the lifetime maximum limit of $10,000 per person for all reproduction treatments for all charges and networks combined.
• Self-administered injectable and oral prescription drugs	For the level of coverage refer to Prescription Drugs and Insulin	For the level of coverage refer to Prescription Drugs and Insulin

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Please refer to the Glossary of Common Terms section for descriptions of AI, IUI, and ART.
- Benefits are subject to the lifetime maximum of $10,000 per person for all reproduction treatments for all charges and networks combined, including injectable prescription drugs administered by a health care professional, and self-administered injectable and oral outpatient prescription drugs.

- For services related to infertility testing please refer to Physician Services.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

- services for or related to reproduction treatments when the number of embryos transferred exceeds the current guidelines developed by the Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine
- services for or related to adoption fees and childbirth classes
- services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- services for or related to reversal of sterilization
- donor ova or sperm, including banking or storage services
- embryo banking or storage services
- services/charges for or related to physician dispensed self-administered prescription drugs
- outpatient prescription drugs for or related to reproduction treatments
- please refer to the General Exclusions section

Skilled Nursing Facility

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• Skilled care ordered by a physician and eligible under Medicare guidelines • Semiprivate room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	80% after you pay the deductible.	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- Coverage is limited to a maximum benefit of 120 days per person per calendar year.
- You must be admitted within 14 days after hospital admission of at least three (3) consecutive days for the same illness.
- If you are unable to obtain a bed in a BlueCard PPO 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 BlueCard PPO level of coverage.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

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

Transplant Coverage

The Plan Covers:	Blue Distinction Centers for Transplant (BDCT) Providers	Non-Blue Distinction Centers for Transplant (BDCT) Providers

The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:
 	
• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell support procedures
 	
• Autologous bone marrow transplant and peripheral stem cell support procedures
 	
• Heart
 	
• Heart - lung
 	
• Kidney – pancreas transplant performed simultaneously (SPK)
 	
• Liver – deceased donor and living donor
 	
• Lung – single or double
 	
• Pancreas transplant – deceased donor and living donor segmental
 	
  ▪ Pancreas transplant alone (PTA)
  ▪ Simultaneous pancreas – kidney transplant (SPK)
  ▪ Pancreas transplant after kidney transplant (PAK)
 	
• Small-bowel and small-bowel/liver
	100% of the Transplant Payment Allowance for the transplant admission.
	
	If you live more than 50 miles from a BDCT Provider, there may be travel benefits available for expenses directly related to a preauthorized transplant. See NOTES.
	
	For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
		Participating Transplant Provider
		
		$5,000 transplant specific copay, then 80% of the Transplant Payment Allowance for the transplant admission after you pay the deductible.
		
		Nonparticipating Transplant Provider
		
		NO COVERAGE.
		
		For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.

NOTES:

- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to Hospital Inpatient and Physician Services.
- **of Prior authorization is recommended for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.**
- Travel benefit-Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.
  - The Plan covers the patient up to $50 per day for lodging and meals when purchased at the transplant facility.
  - The Plan covers a companion/caregiver up to $50 per day for lodging.

- The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
- Total benefit shall not exceed $5,000 per lifetime.
- Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
- Reimbursed expenses are not tax deductible. Consult your tax advisor.

NOT COVERED:

- travel benefits when you are using a Non-BDCT Provider
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description
- transplantation of animal organs and/or tissue
- non-covered travel expenses include but are not limited to: utilities; child care; pet care; security deposits; cable hook-up; dry cleaning; laundry; car rental; and personal items
- travel lodging is not eligible when staying with family or friends
- please refer to the General Exclusions section

DEFINITIONS:

- BDCT Provider means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide 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 peripheral stem cell support procedures.
- Transplant Payment Allowance means the amount the Plan pays for covered services to a BDCT Provider or a Participating Transplant Provider for services related to organ or bone marrow transplant or peripheral stem cell support procedures in the agreement with that provider.

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

Well-Child Care

The Plan Covers:	BlueCard PPO Providers	Out-of-Network Providers
• The following services for a dependent child from birth to age six (6): ▪ preventive services ▪ developmental assessments ▪ laboratory services • Immunizations for a dependent child from birth to age 18	100%	70% after you pay the deductible.

NOTES:

- **Please see the Notification Requirements section.**
- **You must use a BlueCard PPO Provider to obtain the highest level of coverage.**
- For facility charges, please refer to Hospital Outpatient.
- You pay all charges that exceed the allowed amount when you use an Out-of-Network Provider.

NOT COVERED:

- please refer to the General Exclusions section

BENEFIT SUBSTITUTION

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

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

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

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

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

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

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

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatment, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by the Claims Administrator in advance of treatment.
3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.
4. Services that are provided without charge, including services of the clergy.
5. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.
6. Services for or related to therapeutic acupuncture, except for the treatment of chronic pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.
7. Services that are provided for the treatment of an employment-related injury for which you are entitled to make a worker's compensation claim, unless the worker's compensation carrier has disputed the claim.
8. Charges that are eligible, paid or payable, under any automobile personal injury protection that is payable without regard to fault.
9. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
10. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.
11. Services to treat injuries which occur while on military duty that are recognized by the Veterans Administration as services related to service-connected injuries.
12. Services for dependents if you have Faculty/Staff-only coverage.
13. Services that are prohibited by law or regulation.
14. Services which are not within the scope of licensure or certification of a provider.
15. Charges for furnishing medical records or reports and associated delivery charges.
16. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the Benefit Chart.
17. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.
18. Services for or related to mental illness not listed in the most recent edition of *International Classification of Diseases.*
19. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.
20. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offences, competency evaluations, adoption home status, parental competency, and domestic violence programs.

21. Services for or related to room and board for foster care, group homes, incarceration and lodging programs, halfway house services, and skills training.
22. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.
23. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); the treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).
24. Charges made by a health care professional for televideo conferencing services, email, and physician/patient telephone consultations, except for eligible E-Visits and as specified in the Benefit Chart.
25. Services for or related to substance abuse or addictions that are not listed in the most recent edition of the *International Classification of Diseases.*
26. Services for or related to substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition.
27. Services for or related to therapeutic massage.
28. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts.
29. Dental implants, and associated services and/or charges.
30. Services for or related to the replacement of a damaged bridge from an accident-related injury.
31. Services for or related to oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy.
32. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.
33. Room and Board expenses in a residential hospice facility.
34. 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.
35. Admission for diagnostic tests that can be performed on an outpatient basis.
36. Services for or related to private-duty nursing, except as specified in the Benefit Chart.
37. Personal comfort items, such as telephone, television, etc.
38. Communication services provided on an outpatient basis or in the home.
39. Services for or related to sex transformation/gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling.
40. Services for or related to reversal of sterilization.
41. Services for or related to adoption fees and childbirth classes.
42. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.
43. Donor ova or sperm, including banking or storage services.
44. Embryo banking or storage services.

45. Induced termination of a pregnancy is not covered for any reason.
46. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and except as specified in the Benefit Chart.
47. Services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants.
48. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.
49. Blood pressure monitoring devices.
50. Foot orthoses, except as specified in the Benefit Chart.
51. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
52. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.
53. Services for or related to hearing aids or devices, and related fitting or adjustment, except as specified in the Benefit Chart.
54. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
55. Services primarily educational in nature, except as specified in the Benefit Chart.
56. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.
57. Services for or related to developmental delay services, except when medically necessary and provided by an eligible health care provider.
58. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.
59. Services for or related to health clubs and spas.
60. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the member's condition.
61. Custodial care.
62. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
63. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.
64. Services for or related to the repair of scars and blemishes on skin surfaces.

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

66. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart.

67. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.

68. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment: services for or related to homeopathy, or chelation therapy that the Claims Administrator determines is not medically necessary.

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

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

71. Autopsies.

72. Charges for failure to keep scheduled visits.

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

74. Internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.

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

76. Charges for over-the-counter drugs, except as specified in the Benefit Chart; vitamin or dietary supplements; and investigative or non-FDA approved drugs.

77. Smoking cessation drugs without a prescription or documented enrollment in the stop-smoking program.

78. 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.

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

80. Charges for or related to physician dispensed self-administered prescription drugs for reproduction treatments.

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

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

83. Services for or related to fetal tissue transplantation.

Eligible Faculty and Staff

All full time staff working an average of 25 hours per week are eligible; or persons with an approved job sharing arrangement with the University of St. Thomas working 20 hours per week.

Temporary employees are not eligible to receive benefits

Eligible Faculty Members include:

a. Lay Faculty Members: A lay member of St. Thomas' regular full-time faculty with appointments as tenured, tenured tract, limited term or visiting professor who has been issued a contract.

b. Adjunct Faculty Members: A lay member of St. Thomas' adjunct faculty is not eligible to participate in the UST benefit programs. For purposes of determining benefit eligibility, adjunct faculty contracts will not be combined with any other assignments or duties.

c. Administrator/Faculty: A lay faculty member of St. Thomas' regular full-time faculty who has been selected for the contract year to serve as an administrator, who will be regularly employed for at least two thirds time for 12 months per academic year as an administrator as defined in the Fair Labor Standards Act, 29 U.C.S. #213 and regulations hereunder.

d. Priests or Member of Religious Order: A priest or member of a religious order with a faculty contract as outlined in a. or c. above, on whose behalf welfare benefits are not paid to his archdiocesan office or to his or her religious order.

e. Faculty who are Phased Retirement participants that meet the criteria established by the University. Please see the Plan Administrator for eligibility guidelines.

Retirees must contact the Plan Administrator for eligibility information.

Eligible Dependents

Spouse

1. Spouse, meaning:

    a. Legally married opposite gender spouse as defined by the Defense of Marriage Act.

Dependent Children

1. Unmarried natural-born dependent children to age 19.

2. 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.

3. Unmarried stepchildren to age 19.

4. Unmarried legal wards to age 19.

5. Unmarried grandchildren to age 19 who live with you and are claimed as exemptions on your Federal income tax return.

6. Unmarried children of the faculty or staff 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.

Student Dependents

1. 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

   If your dependent child has not graduated or completed a defined course of study, your student dependent may miss any regularly scheduled break in classes including “j-term” and summer break and one (1) academic term 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 scheduled break in classes or the missed academic term, coverage will be terminated at the end of the last month of the missed academic term. For the purposes of this section “academic term” is defined by the educational institution your student dependent attends.

   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.

   c. a full-time student dependent who experiences a catastrophic illness which requires the dependent to take a medical leave of absence based on a written physician’s statement, is allowed extended eligibility for up to 12 months or until the coverage would otherwise have terminated pursuant to the terms and conditions of the Plan, whichever occurs first. Full-time student status is determined by the educational institution.

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

NOTE: Unmarried full-time student dependents that are not currently covered under this Plan may be added as long as they otherwise meet the criteria for full-time student dependent in the eligible dependent section. Written notification must be received within 30 days of enrollment in the educational institution. Coverage starts on the first of the month following the day the Plan Administrator receives the application.

Disabled Dependents

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

   a. primarily dependent upon you;

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

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

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

NOTE: If both you and your spouse are faculty or staff of the University, you may be covered as either a faculty or staff member or as a dependent, but not both. Your eligible dependent children may be covered under either parent’s coverage, but not both.

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 Faculty and Staff

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. However, if your date of hire is the first of the month, your coverage is effective on that date.
2. If the Plan Administrator receives your application more than 30 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual enrollment unless you meet the requirements of the special enrollment period.

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 must reapply for coverage at the next annual enrollment unless your spouse and/or stepchildren meet the requirements of the special enrollment period.

Adding newborns and children placed for adoption

1. If the Plan Administrator receives the application within 90 days of the date of birth, coverage for your newborn child or newborn grandchild starts on the date of birth.

   If the Plan Administrator receives the application within 90 days of the date of placement, coverage for your adopted child starts on the date of placement.
2. If the Plan Administrator receives the application more than 90 days after the date of birth, your newborn child or newborn grandchild must reapply for coverage at the next annual enrollment unless your newborn child or newborn grandchild meets the requirements of the special enrollment period.

   If the Plan Administrator receives the application more than 90 days after the date of placement, your adopted child must reapply for coverage at the next annual enrollment unless your adopted child meets the requirements of the special enrollment period.

Adding disabled children or disabled dependents

1. If the Plan Administrator receives the application within 30 days of the date of eligibility, coverage for your disabled dependent starts on the date of eligibility.
2. If the Plan Administrator receives the application more than 30 days after the date of eligibility, your disabled dependent must reapply for coverage at the next annual enrollment unless your disabled dependent meets the requirements of the special enrollment period.

Special Enrollment Periods

Special enrollment periods are periods when eligible faculty and staff 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

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

2. the faculty and staff member must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;

3. the faculty or staff member's or dependent's coverage is terminated because his/her COBRA continuation has been exhausted (not due to failure to pay the premium or for cause), he/she is no longer eligible for the Plan due to legal separation, divorce, death of the faculty or staff member, termination of employment, reduction in hours, cessation of dependent status, all University 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 faculty or staff member or dependent requested enrollment not later than 30 days after the termination of coverage or University 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 faculty and staff members 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 faculty or staff member is eligible under the terms of the Plan, the faculty or staff member and eligible dependent are eligible for special enrollment when the faculty or staff member acquires a new dependent through marriage, birth, adoption or placement for adoption.

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

Leave of Absence Provision

Faculty and Staff Disability Leave

If you become disabled and receive Short Term or Long Term disability benefits from the University, we will continue to subsidize the cost of your coverage from the date you become disabled for up to 18 months, provided you continue to pay the employee portion of the costs. If you cannot return to work on or before the expiration of those 18 months, you will experience a qualifying event and your COBRA right to continue coverage will be sent to you.

Faculty and Staff-APPROVED UNPAID LEAVE OF ABSENCE

If you stop active work due to an approved, unpaid, non-medical leave of absence and you will be absent from work for a period not to exceed two-months, your employer will continue your Medical coverage as if you were actively working. NOTE: See Family and Medical Leave Act information for a medical leave of absence. During the leave of absence period you remain responsible for your usual contribution toward the cost of coverage. If you fail to return to active work at the end of the scheduled time or you fail to make the required contributions, your coverage ends and you will be offered COBRA continuation coverage as of the first of the month following the date your leave began. If your unpaid leave of absence is approved and scheduled to exceed a two-month duration, your employer will offer COBRA continuation coverage to you and your dependents (if applicable). The COBRA effective date is the first day of the month following the date the leave begins. You and your dependents (if applicable) must be covered under the Plan before the leave begins. Provided you elect to continue your coverage you will be required to pay the usual COBRA continuation costs for your Medical coverage. You will be mailed the notification about COBRA continuation, if applicable to your situation.

Faculty and Staff-FAMILY AND MEDICAL LEAVE ACT

If you are absent from work due to an approved family or medical leave under the Family Medical Leave Act of 1993 (FMLA), coverage will be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the University that you do not intend to return to work. You are responsible for all required contributions during a medical leave.

Faculty-APPROVED SABBATICAL LEAVE

If you are absent from work due to an approved sabbatical leave of absence, coverage will be continued. The University will continue to subsidize the cost of your coverage for the duration of the approved sabbatical leave.

Faculty-COPERATIVE EXCHANGE PROGRAM

If you agree to participate in an approved exchange program, whether in the United States or out of the country, you will continue to be an active employee for purposes of pay and benefits. These types of assignments generally are for one or two semesters. Professors from other universities, who participate in the exchange program and come to the University of St. Thomas, will be handled as new hires, with benefit eligibility determined on the same basis as any other new hire.

Faculty-VISITING PROFESSOR PROGRAM

If you agree to a temporary assignment through the Visiting Professor Program, your employer will offer COBRA continuation coverage to you and your dependents (if applicable). You and your dependents (if applicable) must be covered under the Plan before the leave begins. Provided you elect to continue your coverage you will be required to pay the COBRA continuation costs for your Medical coverage, at the same rate as an active employee. COBRA continuation will be available for the duration of the assignment, which may be as long as two (2) years. You will be mailed the notification about COBRA continuation, if applicable to your situation.

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.
   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, under Section 125 qualifying event.
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 faculty and staff member and spouse divorce or legally separate.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
   a. a covered stepchild is no longer eligible because the faculty and staff member and spouse divorce or legally separate.
   b. the dependent child marries or reaches the dependent-child age limit.
   c. the student dependent child no longer meets the student dependent eligibility requirements.
   d. the dependent child becomes covered as an employee under any health coverage plan sponsored by the employer.
   e. the disabled dependent is no longer eligible.
   f. 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 faculty and staff member 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 faculty and staff member'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 faculty and staff member's or dependent's coverage in full to current paid-to-date.

Certification of Coverage

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

The certification of coverage form will be issued to you if you request it before losing coverage or when you terminate coverage with the Plan and, if applicable, at the expiration of any continuation period. The Claims Administrator will also issue the certification of coverage form if you request a copy at any time within the 24 months after your coverage terminates. To request a certificate of coverage form, please call the customer service number located in the Customer Service section.

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 ***faculty or staff member*** and are covered, you have the right to elect continuation coverage <u>if you lose coverage</u> because of any one (1) of the following qualifying events:

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

If you are the ***ex-spouse/spouse*** of a covered ***faculty or staff member***, you have the right to elect continuation coverage <u>if you lose coverage</u> because of any of the following qualifying events:

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

- The ***faculty or staff member*** becomes enrolled in Medicare.

In the case of a ***dependent child*** of a covered ***faculty or staff member***, 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 ***faculty or staff member***.
- The termination of the ***faculty or staff member's*** employment (for reasons other than gross misconduct) or reduction in the ***faculty or staff member's*** hours of employment with the University.
- Parents' divorce or legal separation.
- The ***faculty or staff member*** 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 University of any of the following events within 60 days of the occurrence of the event:

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

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

University's and Plan Administrator's Notice Obligations

The University has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the ***faculty or staff member***. This 30-day notice to the Plan Administrator is not often used because usually the Plan Administrator is the ***University***. 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 University 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 ***faculty or staff member's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***faculty or staff member's*** becoming enrolled in Medicare.

Election Procedures

You and your dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after 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, an ex-spouse/spouse may not decline coverage for the other ex-spouse/spouse and a parent cannot decline coverage for a non-minor dependent child eligible for coverage. In addition, a dependent may elect continuation coverage even if the covered ***faculty or staff member*** does not elect continuation coverage.

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

How to Elect

Contact the University 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 or legal separation and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse/spouse had lost coverage earlier. The ex-spouse/spouse must notify the University within 60 days after the later divorce or legal separation and establish that the coverage was eliminated earlier in anticipation of divorce or legal separation; and 2) A child born to or placed for adoption with the covered ***faculty or staff member*** during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.)

Qualified beneficiaries 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 faculty or staff members or their dependents, then continuation coverage will be modified in the same way. (Examples: 1) If the University offers an open enrollment period that allows active faculty or staff members 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 faculty or staff members 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 ***faculty or staff member's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

36 Months. If a dependent loses coverage because of the ***faculty or staff member's*** death, divorce, legal separation, the ***faculty or staff member*** 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 ***faculty or staff member,*** or the ***faculty or staff member'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 University 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 University 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 University'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 University 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 ***faculty or staff member'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 ***faculty or staff member'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 ***faculty or staff member's*** termination of employment or reduction of hours.)

  Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month 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 ***faculty or staff member'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 ***faculty or staff member,*** divorce, legal separation, the ***faculty or staff member*** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the ***faculty or staff member'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 ***faculty or staff member's*** Medicare enrollment. The extension applies to the ***faculty or staff member's*** dependents who are qualified beneficiaries.

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

If the qualifying event (***faculty or staff member'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.

- ***University'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 University 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 ***faculty or staff member*** and dependents will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

- The University no longer provides group health coverage to any of its faculty or staff members.

- 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 University.

- After electing continuation, you or your dependents become covered under another group health plan (as an faculty or staff member 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 ***faculty or staff members*** or their dependents who have coverage under the Plan for a reason other than the continuation coverage requirements of federal law.

- Voluntarily canceling your continuation coverage.

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

Children Born to or Placed for Adoption With the Covered Faculty or staff member During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***faculty or staff member*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***faculty or staff member*** is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption, or placement for adoption as outlined in the Eligibility section, and it lasts for as long as continuation coverage lasts for other family members of the ***faculty or staff member***. 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 faculty or staff members 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 you 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 ***faculty or staff member*** or family member is no longer disabled.

Special Second Election Period

Special continuation rights apply to certain faculty or staff members who are eligible for the health coverage tax credit. These faculty or staff members 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 faculty or staff member becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Questions

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

Overview

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

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
• Employment ends (for reasons other than gross misconduct) • Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment)	Faculty or staff member and dependents	Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.
• Divorce or legal separation	Ex-spouse and any dependent children who lose coverage	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Death of faculty or staff member	Surviving spouse and dependent children	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end if the faculty or staff member had lived.
• Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Dependents lose eligibility due to the faculty or staff member's enrollment in Medicare	All dependents	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Retirees of the University filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.

Extensions to 18-month maximum continuation period: • Disability, as determined by the Social Security Administration, of faculty or staff member or dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the faculty or staff member leaves employment; or 2. Date disability ends; or 3. 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.

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

    Therefore, "plan" does not include:

    a. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time); or

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

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

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

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

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

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

    Notes:

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

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

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

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

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

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

Order of Benefits Rules

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

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

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

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

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

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

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

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

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

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

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

      1) first, the plan of the parent with physical custody of the child;

      2) then, the plan that covers the spouse of the parent with physical custody of the child;

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

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

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

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

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

Effect on Benefits of This Plan

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

2. Reduction in This Plan's benefits

   When the sum of:

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

REIMBURSEMENT AND SUBROGATION

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

The Plan's Right of Subrogation

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

Obligation to Reimburse the Plan

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

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

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

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

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

Duty to Cooperate

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

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

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

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

2. bring a legal action against any other party.

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

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

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

Attorneys' Fees and Other Expenses You Incur

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

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

What May Happen to Your Future Benefits

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

Interpretation

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

Plan Administration

Plan Administrator

The general administration of the Plan and the duty to carry out its provisions is vested in the University. The board of directors will perform such duties on behalf of the University, provided it may delegate such duty or any portion thereof to a named person, including faculty and staff, and agents of the University, 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 University 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 faculty or staff members” 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 University 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 faculty or staff member 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 Administration of the University. The Plan Administrator will communicate any adopted changes to the faculty or staff members.

Funding

This Plan is a self-insured medical plan funded by contributions from the University and/or faculty and staff members. Funds for benefit payments are provided by the University 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 University 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 University may not use or disclose PHI for employment-related actions or decisions. The University 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 University and the Plan

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

- Benefits Administrator
- Benefit Technician
- Benefit Specialist

This list includes every faculty or staff member or class of faculty or staff members or other workforce members under the control of the University who may receive PHI relating to the ordinary course of business.

The faculty or staff members, classes of faculty or staff members 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 University will promptly report such instances to the Plan and will cooperate to correct the problem. The University will impose appropriate disciplinary actions on each faculty or staff member 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:	University of St. Thomas Preferred Provider Organization (PPO) Health Care Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
Plan Year:	January 1 through December 31
Plan Number:	505
Funding Medium:	This Plan is self-funded by contributions from the University and/or employees. Funds for benefit payments are provided by the University 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 University 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:	University of St. Thomas Mail AQU217 2115 Summit Ave St. Paul, MN 55105 (651) 962-6521
Plan Sponsor's Employer Identification Number:	41-0693970
Plan Administrator:	University of St. Thomas Mail AQU217 2115 Summit Ave St. Paul, MN 55105 (651) 962-6521
Named Fiduciary for Claims Purposes:	BCBSM
Named Fiduciary for all other Purposes:	University of St. Thomas Mail AQU217 2115 Summit Ave St. Paul, MN 55105 (651) 962-6521

Agent for Services of Legal Process:	Benefit Administrator; Department of Human Resources University of St. Thomas Mail AQU217 2115 Summit Ave St. Paul, MN 55105 (651) 962-6521 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.

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

90dayRx — Participating 90dayRx Retail Pharmacies and Mail Service Pharmacy used for the dispensing of a 90-day supply of long-term prescription drug refills.

Admission — A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Advanced practice nurses — Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).

Allowed amount — The amount 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.

For BlueCard PPO Providers, the allowed amount is the negotiated amount of payment that the BlueCard PPO 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 BlueCard PPO Providers as a result of expected settlements or other factors. The negotiated amount of payment with BlueCard PPO 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 a BlueCard PPO 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.

For Out-of-Network Providers, the allowed amount is the lesser of billed charge or a percentage of what the Plan would pay a BlueCard PPO Provider for the same or similar services.

Artificial Insemination (AI) — The introduction of semen from a donor (which may have been preserved as a specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Reproductive Technologies (ART) — Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine, or artificial insemination), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.

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

Average semiprivate room rate — The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

Blue Distinction Centers for Bariatric Surgery — 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.

BlueCard PPO Provider — Providers who have entered into a Preferred Provider Organization (PPO) service agreement which designates them as a BlueCard PPO Provider with the local Blue Cross and/or Blue Shield Plan.

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

Calendar year — The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care/case management plan — A plan for health care services developed for a specific patient by 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.

Claims Administrator — Blue Cross and Blue Shield of Minnesota

Coinsurance — The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from BlueCard PPO Providers, coinsurance is calculated based on the lesser of the allowed amount or the BlueCard PPO Provider's billed charge. Because payment amounts are negotiated with BlueCard PPO Providers to achieve overall lower costs, the allowed amount for BlueCard PPO 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 BlueCard PPO Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the

stated percentage.

For covered services from Out-of-Network Providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Coinsurance Example:

You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

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

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

Compound drug

A prescription where two or more drugs are mixed together. One of these must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound if only water or sodium chloride solution are added to the active ingredient.

Comprehensive pain management program

A multidisciplinary program including, at a minimum, the following components:

1. a comprehensive physical and psychological evaluation;
2. physical/occupation therapies;
3. a multidisciplinary treatment plan; and
4. a method to report clinical outcomes.

Continuous qualifying creditable coverage

The maintenance of continuous and uninterrupted creditable coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous qualifying creditable coverage if the individual applies for coverage within 63 days of the termination of his or her qualifying creditable coverage.

Copay — The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays.

A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

Cosmetic services — Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Covered services — A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial care — Services to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.

Day treatment — Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible — The amount you must pay toward the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each person and family are shown on the Benefit Chart.

Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Drug therapy supply — A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.

Durable medical equipment — Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

Emergency hold — A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.

Enrollment date — The first day of coverage, or if there has been a waiting period, the first day of the waiting period (typically the date employment begins).

E-Visit — An online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.

Facility — A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, or a home health agency when services are billed on a facility claim.

Family therapy — Behavioral health therapy intended to treat an individual within the context of family relationships. The focus of the treatment is to identify problems or conflicts and to set specific goals for resolving them.

Foot orthoses — Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.

Formulary — The Claims Administrator's formulary is a list of preferred prescription drugs and drug supplies 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 Coverage Committee is responsible for final selection of drugs for this list based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee comprised of actively practicing physicians and pharmacists. The formulary is subject to periodic review and modification by this Committee. Decisions to add or remove drugs are based on the medication’s safety, efficiency, uniqueness, and/or cost.

Freestanding ambulatory surgical center — A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor’s office, or other health care professional’s office.

Group therapy — Behavioral health therapy conducted with multiple patients

Halfway house — Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health care professional
A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, and licensed registered dieticians. 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.

Home health agency
A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.

Hospice care
A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.

Hospital
A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Host Blue
A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that require such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

Illness
A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.

Infertility Testing
Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.

Intensive Outpatient Programs (IOP)
A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

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

Intrauterine Insemination (IUI)
A specific method of artificial insemination in which semen is introduced directly into the uterus.

Investigative
A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

1. the drug or device cannot be lawfully marketed without approval of the

U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients);
3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.

Lifetime maximum

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

Mail service pharmacy

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

Marital/couples therapy

Behavioral health care services for the primary purpose of working through relationship issues.

Marital/couples training

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

Medical emergency

Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

Medically necessary — Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare — A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.

Mental health care professional — A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice, that provides treatment for mental health disorders, substance abuse, or addictions.

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

Mobile crisis services — Face-to-face short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.

Neuro-psychological examinations — Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.

Opioid treatment — Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.

Out-of-Network Provider — Providers who have not entered into a BlueCard PPO service agreement or any service agreement with the local Blue Cross and/or Blue Shield Plan.

Out-of-pocket maximum	The most each person must pay each applicable plan or calendar year toward the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the applicable plan or calendar year. The Benefit Chart lists the out-of-pocket maximum amounts.
Outpatient Behavioral Health Treatment Facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Partial programs	An intensive structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.
Participating Pharmacy	A nationwide pharmaceutical provider that participates in a network for the dispensing of prescription drugs. The network is also called Select Pharmacy Network.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Plan	The plan of benefits established by the Plan Administrator.
Plan year	A 12-month period which begins on the effective date of the Plan and each succeeding 12-month period thereafter.
Preferred Provider Organization (PPO)	A health benefit program that offers the highest level of benefits to you and your dependents when you obtain services from any physician or hospital designated as a BlueCard PPO member.
Prescription drugs	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.

Provider	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.
Qualifying creditable coverage	Health coverage provided through an individual policy; a self-funded or fully-insured group health plan offered by a public or private employer; Medicare; MinnesotaCare; Medical Assistance; 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.
Reproduction Treatment Facility	Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.
Residential Behavioral Health Treatment Facility	A facility licensed under state law in the state in which it is located that provides treatment by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
Retail Health Clinic	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Retail pharmacy	Any licensed pharmacy that you can physically enter to obtain a prescription drug.
Services	Health care service, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.

Skilled care — Services that are medically necessary and 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.

Skilled nursing facility — A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills training — Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment and the requirements of everyday independent living.

Smoking cessation drugs — Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Specialty drugs — Specialty drugs are complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are used to treat serious or chronic medical conditions including, but not limited to: fertility; short stature; multiple sclerosis; hemophilia; hepatitis and rheumatoid arthritis.

Specialty Pharmacy Network — A nationwide pharmaceutical specialty provider that participates in a network for the dispensing of certain oral medications and injectable drugs.

Substance abuse and/or addictions — Alcohol, drug dependence or other addictions as defined in the most current edition of the International Classification of Diseases.

Supervised employees — Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or 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.

Supply — Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:

1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; or
6. informational materials.

Surrogate Pregnancy — An arrangement whereby a woman becomes pregnant for the purpose of gestating and giving birth to a child for others to raise. Pregnancy may have been the result of conventional means, artificial insemination or assisted reproductive technologies.

Televideo conferencing — Interactive audio and video communications permitting real-time communications between a distant site health care professional and the patient whom is present and participating in the televideo visit at a remote facility.

Terminally ill patient	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
Therapeutic camps	A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.
Therapeutic day care (pre-school)	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.
Therapeutic support of foster care	Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child's improved functioning.
Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.
Waiting period	The period of time that must pass before you or your dependents are eligible for coverage under the health plan.