

Medtronic

2017

Medtronic PPO Plan
Medtronic Consumer Health Plan (CHP) with Health
Savings Account (HSA)

CLAIMS ADMINISTERED BY BLUE CROSS AND BLUE SHIELD OF MINNESOTA

Language Access Services

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Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

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ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າເພີ່ມ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yánílt'i'go saad bee yát'i' éi t'áájíik'e bee níká'a'doowolgo éi ná'ahoot'i'. Kojí éi béesh bee hodiílnih áqíęęqíóaqęqíá. TTY biniyęgo éi íáájí' béesh bee hodiílnih.

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.

RIGHTS AND RESPONSIBILITIES

You Have The Right Under This Plan To:

- be treated with respect, dignity and privacy;
- receive quality health care that is friendly and timely;
- have available and accessible medically necessary covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care providers in decisions about your treatment;
- give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the Plan, the Claims Administrator, and its health care providers in accordance with existing law;
- receive information about the Plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the Claims Administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the Claims Administrator and receive a prompt and fair review; and,
- initiate a legal proceeding when experiencing a problem with the Plan or its providers.

You Have The Responsibility Under This Plan To:

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

TABLE OF CONTENTS

INTRODUCTION	1
CUSTOMER SERVICE	2
SPECIAL FEATURES.....	3
COVERAGE INFORMATION.....	4
<i>Choosing A Health Care Provider</i>	<i>4</i>
<i>Your Benefits</i>	<i>5</i>
<i>Payments Made in Error.....</i>	<i>5</i>
<i>Liability for Health Care Expenses</i>	<i>5</i>
<i>Inter-Plan Programs</i>	<i>6</i>
<i>General Provider Payment Methods</i>	<i>8</i>
<i>Recommendations by Health Care Providers</i>	<i>10</i>
<i>Services that are Investigative or not Medically Necessary</i>	<i>11</i>
<i>Fraudulent Practices.....</i>	<i>11</i>
<i>Time Periods</i>	<i>11</i>
<i>Medical Policy Committee and Medical Policies</i>	<i>11</i>
NOTIFICATION REQUIREMENTS	12
<i>Prior Authorization.....</i>	<i>12</i>
<i>Preadmission Notification.....</i>	<i>13</i>
<i>Preadmission Certification.....</i>	<i>13</i>
<i>Emergency Admission Notification.....</i>	<i>14</i>
CLAIMS PROCEDURES.....	15
<i>Types of Claims.....</i>	<i>15</i>
<i>Filing Claims.....</i>	<i>16</i>
<i>Timeframes for Deciding Claims</i>	<i>16</i>
<i>Incomplete Claims.....</i>	<i>17</i>
<i>Notification of Initial Benefit Decision</i>	<i>17</i>
<i>Appeals of Adverse Benefit Determinations</i>	<i>18</i>
<i>Timeframes for Deciding Appeals</i>	<i>19</i>
<i>Notification of Appeal Decision.....</i>	<i>19</i>
<i>Voluntary Appeals</i>	<i>19</i>
<i>External Review.....</i>	<i>20</i>
<i>Additional Provisions</i>	<i>21</i>
PPO BENEFIT CHART	23
<i>Benefit Features, Limitations, and Maximums.....</i>	<i>23</i>
<i>Networks</i>	<i>23</i>
<i>Copays.....</i>	<i>23</i>
<i>Deductibles</i>	<i>24</i>
<i>Out-of-Pocket Maximums.....</i>	<i>25</i>
<i>Lifetime Maximums</i>	<i>25</i>
<i>Benefit Descriptions.....</i>	<i>25</i>
<i>Acupuncture</i>	<i>26</i>
<i>Ambulance</i>	<i>27</i>
<i>Bariatric Surgery</i>	<i>28</i>
<i>Chiropractic Care</i>	<i>30</i>
<i>Dental Care.....</i>	<i>31</i>

Emergency Room	33
Gender Dysphoria	34
Home Health Care	40
Home Infusion Therapy	41
Hospice Care	42
Hospital Inpatient	43
Hospital Outpatient.....	45
Infertility Treatment	47
Knee and Hip Replacement Surgery.....	49
Maternity	51
Medical Equipment, Prosthetics, and Supplies	52
Mental Health Care	55
Physical Therapy, Occupational Therapy, Speech Therapy	57
Physician Services	58
Prescription Drugs.....	62
Preventive Care	67
Reconstructive Surgery.....	69
Skilled Nursing Facility	70
Substance Abuse Care	71
Transplant Coverage.....	72

CHP WITH HSA BENEFIT CHART 74

<i>Benefit Features, Limitations, and Maximums.....</i>	<i>74</i>
Networks	74
Annual Employer Contribution (HSA Benefit Dollars)	74
Deductibles	74
Benefit Features.....	74
Out-of-Pocket Maximums.....	75
Lifetime Maximums	75
Prescription Drugs.....	75

CHP WITH HSA PLAN SPECIFICS..... 77

<i>Benefit Descriptions.....</i>	<i>79</i>
Acupuncture	79
Ambulance	80
Bariatric Surgery	81
Chiropractic Care	83
Dental Care	84
Emergency Room	86
Gender Dysphoria.....	87
Home Health Care	93
Home Infusion Therapy.....	94
Hospice Care	95
Hospital Inpatient	96
Hospital Outpatient.....	98
Infertility Treatment	100
Knee and Hip Replacement Surgery.....	102
Maternity	104
Medical Equipment, Prosthetics, and Supplies	105
Mental Health Care	107
Physical Therapy, Occupational Therapy, Speech Therapy	109
Physician Services	110

Prescription Drugs.....	113
Preventive Care	117
Reconstructive Surgery	119
Skilled Nursing Facility	120
Substance Abuse Care	121
Transplant Coverage.....	122
GENERAL EXCLUSIONS.....	125
ELIGIBILITY	129
<i>Eligible Employees</i>	<i>129</i>
<i>Eligible Dependents.....</i>	<i>129</i>
<i>Effective Date of Coverage.....</i>	<i>130</i>
<i>Special Enrollment Periods</i>	<i>131</i>
TERMINATION OF COVERAGE	132
<i>Termination Events.....</i>	<i>132</i>
<i>Retroactive Termination</i>	<i>132</i>
<i>Extension of Benefits.....</i>	<i>132</i>
<i>Continuation of Group Coverage.....</i>	<i>133</i>
COORDINATION OF BENEFITS.....	139
<i>Definitions.....</i>	<i>139</i>
<i>Order of Benefits Rules</i>	<i>140</i>
<i>Effect on Benefits of This Plan</i>	<i>141</i>
<i>Right to Receive and Release Needed Information</i>	<i>141</i>
<i>Facility of Payment</i>	<i>141</i>
<i>Right of Recovery.....</i>	<i>141</i>
REIMBURSEMENT AND SUBROGATION	142
GENERAL PROVISIONS.....	144
<i>Plan Administration.....</i>	<i>144</i>
<i>Statute of Limitations/Lawsuits.....</i>	<i>145</i>
<i>Termination or Changes to the Plan.....</i>	<i>145</i>
<i>Funding.....</i>	<i>145</i>
<i>Controlling Law.....</i>	<i>145</i>
<i>Privacy of Protected Health Information.....</i>	<i>145</i>
<i>Employee Retirement Income Security Act (ERISA) Statement of Rights</i>	<i>146</i>
<i>Important Plan Information</i>	<i>148</i>
GLOSSARY OF COMMON TERMS	149

INTRODUCTION

This Summary Plan Description (SPD) contains a summary of the Medtronic Preferred Provider Organization (PPO), and Medtronic Consumer Health Plan (CHP) with Health Savings Account (HSA) Medical Plans for benefits effective January 1, 2017.

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

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

These Plans, financed and administered by Medtronic, are self-insured medical plans. Blue Cross and Blue Shield of Minnesota (Blue Cross) 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.

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 on or after January 1, 2017, present your NEW identification (ID) card to the provider who is rendering the services.

If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed on the following page.

CUSTOMER SERVICE

Questions?	<p>The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.</p> <p>Monday through Friday: 7:00 am - 8:00 pm United States Central Time</p> <p>Hours are subject to change without prior notice.</p>
Customer Service Telephone Number	Blue Cross Customer Service Toll free at 1-866-455-8221
Blue Cross Blue Shield Website	www.bluecrossmn.com/mdt
BlueCard Telephone Number	<p>Toll free 1-800-810-2583</p> <p>This number is used to locate providers who participate with Blue Cross and Blue Shield Plans nationwide.</p>
Claims Administrator's Mailing Address	<p>Claims review requests, and written inquiries may be mailed to the address below:</p> <p>Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164</p> <p>Prior authorization requests should be mailed to the following address:</p> <p>Blue Cross and Blue Shield of Minnesota Utilization Management Department P.O. Box 64265 St. Paul, MN 55164</p>
Pharmacy Telephone Number	<p>Toll free 1-800-509-0545</p> <p>This number is used to locate a participating pharmacy.</p>
Stop Smoking Support	<p>Toll free 1-888-662-BLUE (2583)</p> <p>Call to enroll in Stop Smoking Support.</p>
24-Hour Nurse Advice Line Telephone Number	<p>Toll-free 1-800-622-9524</p> <p>Call this number to access health care advice 24 hours a day – seven days a week.</p>
Maternity Management Telephone Number	<p>Toll-free 1-866-489-6948 or (651) 662-1818</p> <p>Call this number to enroll in the Maternity Management program.</p>
Online Care	Access DoctoronDemand.com/bluecrossmn to consult with a physician online 24 hours a day seven (7) days a week.

SPECIAL FEATURES

Maternity Management

The Maternity Management program provides expectant mothers with education and support throughout their pregnancy. This support includes access to a specially trained Health Coach (RN) and online educational information. All pregnant women have access to the program, regardless of their risk. To request further information or to enroll call (651) 662-1818, or toll free 1-866-489-6948.

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 Support

Stop-Smoking Support provides a behavior change program to support members that want to reduce tobacco use. This service is available to all members 18 years of age or older, including those that use smokeless tobacco products. Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583). A Wellness Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns.

Fitness Discounts

Earn up to a \$20 monthly credit (two qualifying adults 18 years of age or older per enrolled family) toward your fitness center dues by working out at least 12 days per month. You can find a participating fitness center at mybluecrossmn.com/mdt. Watch for credits 30-60 days after each month the visit requirement is met.

COVERAGE INFORMATION

Choosing A Health Care Provider

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

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

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

BlueCard PPO Providers (In-Network Providers)

These providers have entered into a specific network contract 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. In-Network Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements for you (refer to the Notification Requirements section). Therefore, it is important that you confirm the provider's status before you receive services. For current provider information call the BlueCard telephone number at 1-800-810-2583, or Blue Cross Customer Service at 1-866-455-8221, or you may access the following website: www.bluecrossmn.com/mdt. 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.

To receive the highest level of benefits for hospital/facility bariatric surgery services, members age 18 and older must use Blue Distinction Centers for Bariatric Surgery as your In-Network Provider.

To receive the highest level of benefits for hospital/facility knee and hip replacement services, members age 18 and older must use Blue Distinction Centers for Knee and Hip Replacement as your In-Network Provider.

Out-of-Network Providers

Some states may have providers who have entered into a network contract with the local Blue Cross and/or Blue Shield Plan, but their agreement does not designate them as a BlueCard PPO Provider. There are other providers who have not entered into a network contract with the local Blue Cross and/or Blue Shield Plan. When you choose these providers, you may have substantial out-of-pocket expense and benefits will be paid at the Out-of-Network level. Some of these providers will, but are **not obligated to**:

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. Members are reimbursed directly by Blue Cross and Blue Cross Blue Shield of Minnesota for Out-of-Network claims. Therefore, it is the member's responsibility to reimburse the Out-of-Network Provider directly.

For benefit information on these providers, refer to the benefit Chart. For information on whether or not you will need to file an Out-of-Network claim with your local Blue Cross and/or Blue Shield Plan, please contact Blue Cross Customer Service at 1-866-455-8221.

Your Benefits

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

Payments Made in Error

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

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers

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

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

Out-of-Network Providers

When you use Out-of-Network Providers for covered services, payment may be based on the allowed amount. Most Out-of-Network 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. This means that you may have substantial out-of-pocket expense when you use an Out-of-Network Provider. In addition you are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum level; and
4. charges for services that are not covered, including services that the Claims Administrator determines are not covered based on claims coding guidelines.

Your claims may be reprocessed due to errors in the allowed amount paid to In-Network Providers, Out-of-Network Participating Providers, or Nonparticipating Providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Inter-Plan Programs

Out-of-Area Services

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

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

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Plan Administrator to provide the specific service or services.

BlueCard® Program

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

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

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

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

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

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

Special Cases: Value-Based Programs

BlueCard Program

If you receive covered health care services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments. Additional information is available from the Claims Administrator upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside the Claims Administrator's Service Area

When covered health care services are provided outside of the Claims Administrator's service area by Nonparticipating Providers the Claims Administrator will pay based on the definition of "Allowed Amount" as set forth in the "Glossary of Common Terms" section of this SPD. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BlueCard Worldwide® Program when accessing covered health care services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, and seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services.

You must contact the Claims Administrator to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered health care services.

Submitting a BlueCard Worldwide Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bluecardworldwide.com. If you need assistance with your claim, submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, and seven days a week.

General Provider Payment Methods

Participating Providers

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

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

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

- **Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments**
 - **Fee-for-Service — Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.**
 - **Discounted Fee-for-Service —** Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
 - **Discounted Fee-for-Service, Withhold and Bonus Payments —** Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 - 20 percent) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

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

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

- **Inpatient Care**

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

- **Outpatient Care**

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

Pharmacy Payment

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

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

Nonparticipating Providers

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under Special Circumstances below), the allowed amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; or (4) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare Advantage allowed charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator. The allowed amount for a Nonparticipating Provider is usually less than the allowed amount for a Participating Provider for the same service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the Plan and **you are responsible for paying the Nonparticipating Provider.** The only exception to this is stated in CLAIMS PROCEDURES, Claims Payment. This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

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

- **Example of payment for Nonparticipating Providers**

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

	Participating Provider	Nonparticipating Provider
Provider charge:	\$150	\$150
Allowed amount:	\$100	\$60
Claims Administrator pays:	\$80 (80 percent of the allowed amount)	\$36 (60 percent of the allowed amount)
Coinsurance member owes:	\$20 (20 percent of the allowed amount)	\$24 (40 percent of the allowed amount)
Difference up to billed charge member owes:	None (provider has agreed to write this off)	\$90 (\$150 minus \$60)
Member pays:	\$20	\$114

The Claims Administrator will, in most cases, pay the benefits for any covered health care services received from a Nonparticipating Provider directly to the member based on the allowed amounts and subject to the other applicable limitations in the Plan. An assignment of benefits from a member to a Nonparticipating Provider generally will not be recognized, except in the instance in which a custodial parent requests, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child.

- **Special Circumstances**

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care, such as hospital-based providers (e.g., anesthesiologists) who may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law. Please refer to Emergency Care for coverage of benefits.

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

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

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

Recommendations by Health Care Providers

Referrals are not required. Your provider may suggest that you receive treatment from a specific provider or receive a specific treatment. Even though your provider may recommend or provide written authorization for a referral or certain services, the provider may be an Out-of-Network Provider or the recommended services may be covered at a lesser level of benefits or be specifically excluded. When these services are referred or recommended, a written authorization from your provider does not override any specific network requirements, notification requirements, or Plan benefits, limitations or exclusions.

Services that are Investigative or not Medically Necessary

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

Fraudulent Practices

Coverage for you or your dependents may be terminated if you or any of your dependents engage in fraudulent conduct and/or intentional misrepresentation of material facts that relate to any person's eligibility for coverage. Examples of conduct which will be considered fraud on the Program and/or intentional misrepresentation include, but are not limited to: misstatements or failure to disclose relevant information about medical history (if required), eligibility status, or changes in your coverage elections for enrollment purposes. For claim purposes, examples of fraudulent conduct and/or intentional misrepresentation include, but are not limited to: submitting fraudulent, altered, or duplicate billings for personal gain, and/or allowing a person who is not eligible for coverage under the Plan to use your or your dependent's coverage. If it is determined that such conduct has occurred, Medtronic may direct the Claims Administrator to terminate coverage for you and any covered dependents retroactive to its effective date and you may be required to repay any benefits, employer contributions and any other costs incurred by Medtronic to provide coverage that was based on falsified information. Employees may be subject to discipline, including termination of employment, and Medtronic reserves the right to refer the situation to the authorities for possible prosecution, imposition of criminal and civil fines and imprisonment by state and/or federal law enforcement authorities.

Time Periods

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

Medical Policy Committee and Medical Policies

The Claims Administrator's Medical Policy Committee develops medical policies that determine 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. From time to time new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the Claims Administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may be required. The Claims Administrator's medical policies may be found at the Claims Administrator's website and are hereby incorporated by reference.

NOTIFICATION REQUIREMENTS

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

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

Prior Authorization

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

For **inpatient hospital/facility services**, all In-Network Providers and Out-of-Network Participating Providers are required to obtain prior authorization for you. You are responsible for obtaining prior authorization when receiving **inpatient hospital/facility services** from Nonparticipating Providers.

For **outpatient hospital/facility services or professional services**, Minnesota In-Network Providers and Minnesota Out-of-Network Participating Providers are required to obtain prior authorization for you. **You are responsible for obtaining prior authorization when you use Nonparticipating Providers in Minnesota and any provider outside Minnesota.** However, some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will provide for you.

Minnesota Participating Providers who do not obtain prior authorization for you are responsible for the charges if the services are found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges. The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

The prior authorization list is subject to change due to changes in the Claims Administrator's medical policy. The Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Claims Administrator's website at www.bluecrossmn.com/mdt or by calling Customer Service.

- **Cosmetic versus medically necessary procedures including, but not limited to:** brow ptosis repair; excision of redundant skin (including panniculectomy); reduction mammoplasty; rhinoplasty; scar excision/revision; and mastopexy
- **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; intravenous immunoglobulin (IVIG); oral fentanyl; subcutaneous immunoglobulin; rituximab for off-label usage; NPlate; Promacta; Tysabri; Cinryze; intravitreal implants; insulin-like growth factors; chelation therapy; and botulinum toxin injections for off-label usage
- **Durable Medical Equipment (DME), prosthetics and supplies including but not limited to:** unlisted DME codes over \$1,000; functional neuromuscular electrical stimulation; manual and motorized wheelchairs and scooters; respiratory oscillatory devices; heavy duty and enclosed hospital beds; pressure reducing support surfaces (group 2 and 3); wound healing treatment; implantable hearing devices or prosthetics; continuous glucose monitors; amino acid-based elemental formula; bone growth stimulators; communication assist devices; microprocessor controlled prosthetics
- **Genetic testing including, but not limited to:** hereditary breast cancer and/or ovarian cancer
- **Home health care**
- **Home infusion care involving drugs for which the Claims Administrator requires prior authorization**
- **Humanitarian Use Devices** (defined as devices that are intended to benefit patients by treating or diagnosing disease or condition that affects fewer than 4,000 individuals in the United States per year, classified under the FDA Humanitarian Device Exemption)

- **Imaging services including, but not limited to:** breast magnetic resonance imaging (MRI); CT colonography (virtual colonoscopy)
- **Infertility treatment**
- **Surgical procedures including, but not limited to:** bariatric surgery; hyperhidrosis surgery; surgical treatment for gender dysphoria; spinal cord stimulators; surgical treatment of obstructive sleep apnea and upper airway resistance syndrome; vagus nerve stimulation (for all conditions); spinal fusion; pelvic floor stimulation; and ventricular assist devices
- **Transplants**, except kidney and cornea

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

Preadmission Notification

Preadmission notification is a process whereby the provider or you inform the Claims Administrator that you will be admitted for inpatient hospitalization services. This notice is required in advance of being admitted for inpatient care for any type of non-emergency admission and for partial hospitalization.

All In-Network Providers and Out-of-Network Participating Providers are required to provide preadmission notification for you.

If you are going to receive nonemergency care from Nonparticipating Providers, you are required to provide preadmission notification to the Claims Administrator. However, some of these providers may provide preadmission notification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Refer to Prior Authorization in this section. Minnesota Participating Providers who do not obtain preadmission notification for you are responsible for the charges, if the admission is found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

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

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

Preadmission Certification

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

All In-Network Providers and Out-of-Network Participating Providers will obtain preadmission certification for you.

If you are going to receive nonemergency care from Nonparticipating Providers, you are required to provide preadmission certification to the Claims Administrator. However, some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Refer to Prior Authorization in this section. Minnesota Participating Providers who do not obtain preadmission certification for you are responsible for the charges if the admission is found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or a Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

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

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

Emergency Admission Notification

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

All In-Network Providers and Out-of-Network Participating Providers are required to provide emergency admission notification for you and are responsible for charges for any services found to be not medically necessary.

If you receive care from Nonparticipating Providers, you are required to provide emergency admission notification to the Claims Administrator within 48 hours of the admission or as soon as reasonably possible after admission for pregnancy, medical emergency, or injury. However, some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you. **If this notification is not provided and it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

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

CLAIMS PROCEDURES

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

Types of Claims

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

Pre-service Claim

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

Urgent Care Claim

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

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

Concurrent Care Claim

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

Post-service Claim

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

Change in Claim Type

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

Filing Claims

Except for Urgent Care Claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for Plan benefits to the Claims Administrator. A claimant is not responsible for submitting claims for services received from 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 by calling 1-866-455-8221.

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 24 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

If you are covered under a plan offered by a state health plan, a city, county, school district, or Service Cooperative, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

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

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;
5. The Claims Administrator will give no deference to the initial benefit decision;
6. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
7. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice;
9. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator;
10. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The Claims Administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

Filing Appeals

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

Urgent Care Appeals

An urgent care appeal may be submitted by calling 1-866-455-8221. The Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

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

Pre-Service Claims

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

Post-service Claims

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

Concurrent Care Claims

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

Notification of Appeal Decision

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

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

Voluntary Appeals

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

External Review

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:
 - a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
 - b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;
 - c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and
 - d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the Claims Administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.
2. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

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

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

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

- a. your medical records;
- b. the attending health care professional's recommendation;
- c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
- d. the terms of your Plan;
- e. evidence-based practice guidelines;
- f. any applicable clinical review criteria developed and used by the claims administrator; and
- g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

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

Expedited External Review

1. You may request an expedited external review when you receive:
 - a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

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

Additional Provisions

Authorized Representative

A claimant may appoint an "authorized representative" to act on his or her behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. 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.

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the Claims Administrator.

Claims Payment

When a claimant uses providers who have signed a BlueCard PPO network contract with the local Blue Cross and Blue Shield Plans, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Claims Administrator.

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

No Third Party Beneficiaries

The Plan benefits described in this Summary Plan Description are intended solely for the benefit of you and your covered dependents. No person who is not a Plan participant or dependent of a Plan participant may bring a legal or equitable claim or cause of action pursuant to this Summary Plan Description as an intended or third party beneficiary or assignee hereof.

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, care management, quality improvement activities, reimbursement and subrogation, 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.

PPO BENEFIT CHART

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

Benefit Features, Limitations, and Maximums

Networks

- In-Network Providers participating with this Plan BlueCard PPO Network

Benefit Features

Your Liability

Copays

- General practice office visit copay \$20 per visit

General practice providers: General practice; Family practice; Internal medicine; Pediatrics; Multispecialty clinic; Pediatric nurse practitioner; Adult nurse practitioner; Family nurse practitioner; and Physician assistant.

- Retail health clinic (Convenience care) copay \$10 per visit
- Urgent care copay \$20 per visit
- Specialist office visit copay \$40 per visit

- Emergency room facility copay \$150 per visit

Prescription Drug Copays

Participating Pharmacies and Mail Order Program			
Type of Drug	Choice Rx Network Participating Pharmacy	Other In-Network Participating Retail Pharmacies	PrimeMail Mail Order Program
Generic drugs for Diabetes, High Blood Pressure, and Cholesterol	Plan pays 100% when you purchase a 90-day supply through a Choice Rx participating pharmacy or through the Mail Order Program. If you purchase these generic drugs through other participating pharmacies, you can only obtain a 30-day supply and your cost is determined per the schedule below.		
Generic drug copays	For a 34-day supply, you pay \$10 per prescription* For a 90-day supply, you pay \$20 per prescription*	For a 34-day supply, you pay \$15 per prescription* 90-day supply not available	For a 90-day supply you pay \$30 per prescription*

FlexRx preferred brand name drug copay	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$30 minimum and \$60 maximum copayments) For a 90-day supply, you pay \$60*	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$30 minimum and \$60 maximum copayments) 90-day supply not available	For a 90-day supply, you pay \$60*
Non-preferred brand name drug copay	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$50 minimum and \$100 maximum copayments) For a 90-day supply, you pay \$100*	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$50 minimum and \$100 maximum copayments) 90-day supply not available	For a 90-day supply, you pay \$100*
<p>*Or price of the prescription, whichever is less</p> <p>If you get a prescription filled Out-of-Network, coverage is 100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.</p>			
Designated Specialty drugs purchased through a Specialty pharmacy network supplier	<p>For a (1-31 day supply): 20% up to a maximum of \$150</p> <p>For a (32-90 day supply): 20% up to a maximum of \$300</p> <p>Note: The Prime Specialty Pharmacy Network must be used for obtaining specialty drugs. There is no coverage for Out-of-Network Providers.</p>		

Deductibles

(Does not include copays)

- In-Network Providers
 - \$500 per person per calendar year
 - \$1,000 per family per calendar year
- Out-of-Network Providers
 - \$700 per person per calendar year
 - \$1,400 per family per calendar year

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

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

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

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
The following items are applied toward the out-of-pocket maximum:	
<ol style="list-style-type: none"> 1. copays; 2. prescription drug copays; 3. coinsurance; and 4. deductibles. 	
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.	
<ul style="list-style-type: none"> • In-Network Providers 	\$3,500 per person per calendar year
	\$7,000 per family per calendar year
<ul style="list-style-type: none"> • Out-of-Network Providers 	\$4,700 per person per calendar year
	\$9,400 per family per calendar year
The amounts accumulated toward the out-of-pocket maximum are applied to services provided by both the In-Network Providers and Out-of-Network Providers.	
Amounts accumulated toward the In-Network out-of-pocket maximum also accumulate toward the Out-of-Network out-of-pocket maximum. When the In-Network out-of-pocket maximum is satisfied, covered services from In-Network Providers will be paid at 100 percent of the allowed amount.	
Amounts accumulated toward the Out-of-Network out-of-pocket maximum also accumulate toward the In-Network out-of-pocket maximum. When the Out-of-Network out-of-pocket maximum is satisfied, the Claims Administrator considers both the In-Network and Out-of-Network out-of-pocket maximums satisfied and covered services from all providers will be paid at 100 percent of the allowed amount.	
Lifetime Maximums	
<ul style="list-style-type: none"> • Infertility treatment and drugs 	\$15,000 per person across all health plans sponsored by the Plan Administrator.
	\$5,000 per person across all health plans sponsored by the Plan Administrator.
<ul style="list-style-type: none"> • Total benefits paid to all other providers combined 	Unlimited

Benefit Descriptions

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

Acupuncture

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Acupuncture services	100% after you pay the \$20 general practice or \$40 specialist office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Acupuncture has an annual benefit maximum of 12 visits per person all networks combined.

NOT COVERED:

- acupuncture services for the treatment of weight loss or smoking cessation
 - please refer to the General Exclusions section
-

Ambulance

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the conditionMedically 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 In-Network deductible.

NOTES:

- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

NOT COVERED:

- transportation services that are not medically necessary for basic or advanced life support
- transportation services that are mainly for your convenience including costs related to transportation (to a facility that is not the nearest medical facility equipped to treat the condition)
- please refer to the General Exclusions section

Bariatric Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Medically necessary inpatient hospital/facility services for bariatric surgery from admission to discharge <ul style="list-style-type: none"> semiprivate room and board and general nursing care (private room is covered only when medically necessary) intensive care and other special care units operating, recovery, and treatment rooms anesthesia prescription drugs and supplies used during a covered hospital stay lab and diagnostic imaging Medically necessary outpatient hospital/facility services for bariatric surgery: <ul style="list-style-type: none"> scheduled surgery/anesthesia lab and diagnostic imaging all other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery 	<p>Members age 18 and older:</p> <p>80% after you pay the deductible when you use Blue Distinction Centers for Bariatric Surgery.</p> <hr/> <p>Members age 17 and younger:</p> <p>80% after you pay the deductible when you use In-Network Providers.</p>	<p>Members age 18 and older:</p> <p>50% after you pay the In-Network deductible, plus you pay any charges billed to you that exceed the allowed amount when you use an Out-of-Network Participating Provider.</p> <hr/> <p>50% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount when you use a Nonparticipating Provider.</p> <hr/> <p>Members age 17 and younger:</p> <p>50% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>
The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Professional services for bariatric surgery to correct morbid obesity, including: <ul style="list-style-type: none"> anesthesia assistant surgeon 	<p><u>Services performed in an office:</u></p> <p>100% after you pay the \$20 general practice or \$40 specialist office visit copay for the office visit charge; 100% for all other eligible services.</p> <p><u>Services performed in a facility:</u></p> <p>80% after you pay the deductible.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.
- Eligible services you receive from facility Out-of-Network Participating Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.

- **As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.**
- **All requests for prior authorization must be submitted in writing to:**

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

- There may be a travel benefit available for expenses directly related to a preauthorized bariatric surgery, if the patient is age 18 or older and lives more than 50 miles from a Blue Distinction Centers for Bariatric Surgery, and services are performed at a Blue Distinction Centers for Bariatric Surgery. Eligible benefits are paid at 100 percent up to a maximum of \$2,500 per person per calendar year. For more information, call Customer Service.
- For a list of Blue Distinction Centers for Bariatric Surgery, call Customer Service or visit the Claims Administrator's website at www.bluecrossmn.com/mdt.
- For pre-operative and post-operative bariatric services, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Out-of-Network Participating Provider means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan but is not in the Blue Distinction Network.

NOT COVERED:

- please refer to the General Exclusions section
-

Chiropractic Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Chiropractic care Manipulations Therapies Other chiropractic services 	100% after you pay the \$40 specialist office visit copay for the office visit charge; 100% for all other eligible services.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Chiropractic care is limited to a benefit maximum of 30 visits per person per calendar year for all networks combined. Lab and diagnostic imaging do not accumulate toward the visit maximum.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.
- An office visit copay will be applied to the office visit, evaluation, or manipulation not to exceed one (1) copay per visit.

NOT COVERED:

- services 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 non-medical 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 therapy to treat the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Dental Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<p>This is not a dental plan. The following limited dental-related coverage is provided:</p> <ul style="list-style-type: none"> Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy, natural teeth including: <ul style="list-style-type: none"> dental implants (see NOTES) 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19, including: <ul style="list-style-type: none"> dental implants removal of impacted teeth or tooth extractions related orthodontia related oral surgery bone grafts Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder (except as noted below) 	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Orthodontic services and supplies for the treatment of temporomandibular joint (TMJ) disorder 	50% after you pay the deductible.	50% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services, treatment and/or restoration of a sound and healthy, natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy, natural teeth, crowns, fillings and bridges.
- A sound and healthy, natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy, natural tooth.
- Accident-related dental implants are covered only for two (2) of the four (4) teeth: number seven (7), eight (8), number nine (9), and number 10, AND only for two (2) of the four (4) teeth: number 23, number 24, number 25 and number 26.
- The Plan covers anesthesia provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.

- Orthognathic surgery is covered for the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder and accepted medically necessary treatments as determined by the Claims Administrator.
- Orthodontic services and supplies for the treatment of temporomandibular joint disorder and craniomandibular disorder care services have a lifetime benefit maximum of \$5,000 per person across all health plans sponsored by the Plan Administrator.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or dental prosthesis.
- Please note that benefits may be available through your dental coverage.

NOT COVERED:

- all orthodontia, except as specified in the Benefit Chart
 - dental services to treat an injury from biting or chewing
 - dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
 - dental implants and any associated services and/or charges, except as specified in the Benefit Chart
 - removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as specified in the Benefit Chart
 - accident-related dental services initiated after 12 months from the date of injury or 12 months of your effective date of coverage under this Plan or occurring more than 24 months after the date of initial treatment
 - replacement of a damaged dental bridge from an accident-related injury
 - osteotomies and other procedures associated with the fitting of dentures or dental implants, except as specified in the Benefit Chart
 - oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy
 - services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
 - services to treat bruxism, including dental splints
 - please refer to the General Exclusions section
-

Emergency Room

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">• Outpatient hospital/facility emergency room charges• Outpatient health care professional charges• Take-home prescription drugs	100% after you pay the \$150 emergency room facility copay.	100% after you pay the \$150 emergency room facility copay.

NOTES:

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

NOT COVERED:

- please refer to the General Exclusions section
-

Gender Dysphoria

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Inpatient hospital/facility charges for medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> 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 Outpatient hospital/facility charges for medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> Scheduled surgery/anesthesia lab and diagnostic imaging all other outpatient hospital care Health care professional charges for mental health, medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> office visit urgent Care outpatient professional visit E-Visit lab and diagnostic imaging inpatient hospital/facility visits during a covered admission outpatient hospital/facility visits anesthesia by a provider other than the operating or assisting provider surgery assistant surgeon injectable drugs administered by a health care professional services administered by an aesthetician 	80% after you pay the deductible.	80% after you pay the deductible.
<ul style="list-style-type: none"> Prescription drug charges for the treatment of Gender Dysphoria 	For the level of coverage, refer to Prescription Drugs.	For the level of coverage, refer to Prescription Drugs.

NOTES:

- Travel benefit - Eligible when you live more than 50 miles from a provider for gender reassignment surgery.
 - The Plan covers the patient up to \$50 per day for lodging.
 - 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 to the facility.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person per lifetime.
- Prior authorization is required for Gender Dysphoria services. Please see the Notification Requirements section.
- **Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.**
- **Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the World Professional Association for Transgender Health (WPATH) Version 7, may consist of several interventions with the type and sequence of interventions differing from person to person. These include psychological and social interventions, continual experience living in the identity-congruent gender role, treatment with hormones and surgery to change the genitalia and other sex characteristics to that of the identity-congruent gender.**
- **All requests for prior authorization must be submitted in writing to:**

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

Criteria for All Surgical Treatment

- Surgical treatment of gender dysphoria may be considered **MEDICALLY NECESSARY** when **all** of the following criteria have been met. These criteria are based on the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, from the World Professional Association for Transgender Health, Version 7.
 1. A comprehensive diagnostic evaluation has been completed by a psychiatrist, a clinical psychologist, or other licensed mental health professional* who:
 - a. Is experienced in the evaluation and treatment of gender dysphoria and
 - b. Has competence in the diagnosis of gender nonconforming identities and expressions, as well as in diagnosing possible comorbid disorders such as psychotic disorders, personality disorders, and substance related disorders.
 - c. Has the ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; and
 - d. Meets the Minnesota Department of Human Services qualifications for a mental health professional, as set forth in Minn.Stat.245.4871, subds. 26 and 27 (2015) and Minn.Stat.245.462, subds. 17 and 18 (2015). Providers outside Minnesota must be appropriately licensed according to applicable state law; **AND**
 2. Based on the comprehensive evaluation, the individual meets the diagnostic criteria for gender dysphoria in adolescents and adults per the *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM 5):
 - a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration as manifested by **at least two** of the following:
 - i. A marked incongruence between one's experienced/expressed gender and primary and/or

secondary sex characteristics.

- ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
- iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.
- iv. A strong desire to be the other gender (or some alternative gender different from one's assigned gender).
- v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- vi. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

AND

- b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Breast surgery

- Mastectomy and creation of a male chest in female-to-male members may be considered **MEDICALLY NECESSARY** when the criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota). Requests for breast surgery for a member younger than 18 years of age will be reviewed by medical director; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled.
 - **NOTE: Hormone therapy is not a prerequisite for mastectomy for female-to-male members.** The *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* Version 7 from the World Professional Association for Transgender Health (WPATH) state the following: "Chest surgery in FtM (female-to-male) patients could be carried out (before age of majority) preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."
- Breast augmentation (e.g. implants/lipofilling) may be considered **MEDICALLY NECESSARY** in male-to-female members when criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota). Requests for breast surgery for a member younger than 18 years of age will be reviewed by medical director; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled.
 - **NOTE: Hormone therapy is not a prerequisite for breast augmentation for male-to-female members.** The *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* Version 7 from the World Professional Association for Transgender Health (WPATH) state the following: "Although not an explicit criterion, it is recommended that MtF (male-to-female) patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results."

1. Documentation Requirements:

- a. One letter of recommendation must be provided to a health plan representative from a qualified mental health professional. The letter must address **all** of the following:
 - i. The member's general identifying characteristics; and

- ii. Results of the member's psychosocial assessment, including any diagnoses; and
- iii. The duration of the mental health professional's relationship with the member including the type of evaluation and therapy or counseling to date; and
- iv. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; and
- v. A statement about the fact that informed consent has been obtained from the patient; and
- vi. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
- vii. The health plan and the physician responsible for breast removal or augmentation must receive this letter and recommendations for surgery and the surgical treatment must be authorized by the health plan prior to its occurrence. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the member's chart.

Genital surgery

- Hysterectomy and salpingo-oophorectomy in female-to-male members and orchiectomy in male-to-female members may be considered **MEDICALLY NECESSARY** when the criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota); and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
 - The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals, unless hormones are not clinically indicated for the individual.
- Metoidioplasty or phalloplasty in female-to-male members and vaginoplasty in male-to-female members may be considered **MEDICALLY NECESSARY** when criteria in section I **and** the following criteria are met:
 - The member is 18 years of age or older; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
 - The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals, unless hormones are not clinically indicated for the individual; and
 - The member has completed 12 continuous months of living in a gender role that is congruent with their gender identity.
- Documentation Requirements
 - Two letters of recommendation from licensed mental health professionals have been obtained; one must be from a licensed doctoral level clinical psychologist or a psychiatrist.
 - Both letters must include all of the information listed in the Documentation Requirements 1-6, above, in section II.
 - These letters must be presented to the health plan and to the surgeon prior to genital surgery. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the patient's chart.

Overview of typical Surgical Procedures for the Treatment of Patients with Gender Dysphoria from the World Professional Association for Transgender Health Standards of Care, version 7

- For the Male-to-Female (MtF) Patient, Surgical Procedures may include the following:
 - Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
 - Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
 - Nongenital, nonbreast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, hair removal, and various aesthetic procedures.

- For the Female-to-Male (FtM) Patient, Surgical Procedures may include the following:
 - Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
 - Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;
 - Nongenital, nonbreast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.
- Typical surgical procedures for the Treatment of Patients with Gender Dysphoria are covered if they are determined to be Medically Necessary by the patient's psychiatrist, psychologist, or other licensed mental health professional who is experienced in the evaluation and treatment of gender dysphoria and part of a comprehensive treatment plan;
- Medically necessary facial and pre-surgical genital hair removal by electrolysis or laser performed by a licensed aesthetician is covered under the health plan.

The treatment of children and adolescents with Gender Dysphoria

- The assessment and treatment of children and adolescents with Gender Dysphoria follows the WPATH Standards of Care v7, including the specific competency requirements of mental health professionals working with children or adolescents with Gender Dysphoria;
- The plan covers fully reversible physical interventions for adolescents involving the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty;
- Two goals justify intervention with puberty-suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment;
- Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for Puberty-Suppressing Hormones

- In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met:
 1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
 2. Gender dysphoria emerged or worsened with the onset of puberty;
 3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
 4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
- Risks of Withholding Medical Treatment for Adolescents;
- Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

(WPATH Standards of Care, version 7)

- Preventive health screening guidelines developed for the general population are appropriate for transgender persons for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy.

- Gender-specific preventive services are also necessary for transgender persons appropriate to their anatomy.

Examples include the following:

- Routine Pap smears should be performed as recommended if cervical tissue is present in female-to-male transgender persons;
 - If mastectomy is not performed, mammograms should be performed as recommended.
 - Male-to-female transgender persons treated with estrogen should follow the same screening guidelines for breast cancer as those for all women;
 - Screening for prostate cancer should be performed as recommended for those persons who have retained their prostate.
-

Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to: <ul style="list-style-type: none"> ▪ intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> - licensed registered nurse - licensed practical nurse ▪ services provided by a medical technologist ▪ services provided by a licensed dietician ▪ services provided by a respiratory therapist ▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ prescription drugs 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Coverage is limited to a benefit maximum of 40 visits per person per calendar year.
- Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other preapproved home health care agency consists of up to two (2) consecutive hours per date of service.
- The one (1) home health care visit following early maternity discharge does not apply to the 40-visit maximum.
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For supplies and durable medical equipment billed by a Home Health Agency, refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. Refer to Physician Services.
-

NOT COVERED:

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care - refer to Skilled nursing care - extended hours, Skilled nursing care - intermittent hours, and Skilled care in the Glossary of Common Terms section
- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section

Home Infusion Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Home infusion therapy services when ordered by a physician • Solutions and pharmaceutical additives and dispensing services • Durable medical equipment • Ancillary medical supplies • Nursing services to <ul style="list-style-type: none"> ▪ train you or your caregiver ▪ monitor your home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

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
- investigative or non-FDA approved drugs, except as required by law
- please refer to the General Exclusions section

Hospice Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice, including: <ul style="list-style-type: none"> routine home care continuous home care inpatient respite care general inpatient care 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- 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.
- Coverage for inpatient respite care is for the relief of the patient's primary caregiver and is limited to not more than five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

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

Hospital Inpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Room and board and general nursing care 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 Take-home prescription drugs 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Conditional living donor kidney transplants when provided by an approved Mayo Clinic facility (see NOTES) 	80% after you pay the deductible.	NO COVERAGE.
<ul style="list-style-type: none"> Palliative care 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major transplant or 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 provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.
- For hospital/facility charges for bariatric surgery, refer to Bariatric Surgery.
- For hospital/facility charges for knee and hip replacement surgery, refer to Knee and Hip Replacement Surgery.
- The Plan covers services related to artificial cervical disc procedures.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

- Travel benefit- (Conditional living donor kidney transplant) Eligible when you travel more than 50 miles to obtain transplant care at an approved Mayo Clinic facility or when the approved Mayo Clinic facility provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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 expenses for a kidney donor
 - communication services provided on an outpatient basis or in the home
 - kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
 - kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
 - services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care- refer to Skilled nursing care - extended hours, Skilled nursing care - intermittent hours, and Skilled care in the Glossary of Common Terms section
 - please refer to the General Exclusions section
-

Hospital Outpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Scheduled surgery/anesthesia Radiation and chemotherapy Kidney dialysis Respiratory therapy Lab and diagnostic imaging, except as noted below Medical nutrition therapy Take-home prescription drugs All other outpatient hospital care, except as noted below 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Physical, occupational, and speech therapy 	100% after you pay the \$40 specialist copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Facility urgent care services: <ul style="list-style-type: none"> urgent care facility visit lab and diagnostic imaging all other facility services for urgent care 	100% after you pay the \$20 urgent care copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Magnetic Resonance Imaging (MRI) of the breast Genetic testing for individuals at high risk for breast cancer or ovarian cancer Specific services as part of a chronic condition when related to a diabetes diagnosis including, but not limited to: <ul style="list-style-type: none"> office visits (every six (6) months) annual foot exams and foot care annual influenza vaccine cholesterol, triglycerides, plasma glucose, hemoglobin and A1C testing annual serum creatinine, liver function testing, and micro albuminuria screening annual eye exam outpatient self-management training and education, including medical nutrition therapy Palliative care 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

<ul style="list-style-type: none"> Specific services as part of a chronic condition for: <ul style="list-style-type: none"> diabetes hyperlipidemia hypertension such as: <ul style="list-style-type: none"> high blood pressure <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic annual lab services including: 12-lead ECG, urinalysis, fasting blood glucose or A1C, hematocrit, serum sodium, potassium, creatinine, calcium, and lipid profile high cholesterol <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic lab services including: ALT or AST, CPK, fasting lipid panel or lipid panel with direct LDL and transaminase 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
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NOTES:

- Physical therapy is limited to an annual benefit maximum of 50 visits per person, for all networks combined, without prior authorization. This limit is also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- Speech therapy and occupational therapy are limited to an annual benefit maximum of 40 visits per person for each type of service, for all networks combined, without prior authorization. These limits are also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- The copay/coinsurance is waived for two (2) visits per person per calendar year for medical nutrition therapy when you use an In-Network Provider.
- The Plan covers anesthesia provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- For hospital/facility charges for bariatric surgery, refer to Bariatric Surgery.
- For hospital/facility charges for knee and hip replacement surgery, refer to Knee and Hip Replacement Surgery.
- The Plan covers services related to artificial cervical disc procedures.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

NOT COVERED:

- please refer to the General Exclusions section

Infertility Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Artificial insemination (AI) and intrauterine insemination (IUI) procedures Non-investigative assisted reproductive technologies (ART), procedures and supplies when ordered by a board-certified or board-eligible reproductive endocrinology physician, and furnished in a medical facility approved by the Claims Administrator as a provider of ART services and supplies. No benefits are paid at facilities other than those approved by the Claims Administrator. No benefits are paid for services the Claims Administrator determines are not medically necessary. Embryo freezing and storage (up to 24 months) for embryos produced from one (1) cycle for a member who will undergo cancer treatment that is expected to render them infertile Related services and supplies 	80% after you pay the deductible up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.
<ul style="list-style-type: none"> Physician administered infertility drugs in the office Oral prescription drugs to treat infertility dispensed by a retail pharmacy 	50% up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.	50%, plus you pay any charges billed to you that exceed the allowed amount up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.
<ul style="list-style-type: none"> Take-home prescription drugs 	For the level of coverage, refer to Prescription Drugs and Insulin.	For the level of coverage, refer to Prescription Drugs and Insulin.
<ul style="list-style-type: none"> Self-administered injectable prescription drugs to treat infertility dispensed by a retail pharmacy <p>Up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.</p>	<p>100% after you pay the following:</p> <p><u>For a (1-31 day supply):</u></p> <p>20% up to a maximum of \$150</p> <p><u>For a (32-90 day supply):</u></p> <p>20% up to a maximum of \$300</p>	NO COVERAGE.

NOTES:

- The \$15,000 lifetime maximum for Infertility treatment and drugs is for all networks combined across all health plans sponsored by the Plan Administrator.
- One (1) embryo may be implanted per person per cycle.
- A cycle is defined as one (1) partial or complete fertilization attempt extending through the implantation phase only.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.

NOT COVERED:

- services for infertility treatments when the number of embryos implanted exceeds one (1)
 - services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
 - donor ova or sperm
 - services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
 - services/charges for or related to physician dispensed self-administered prescription drugs
 - services and prescription drugs for or related to gender selection services
 - please refer to the General Exclusions section
-

Knee and Hip Replacement Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Medically necessary inpatient hospital/facility services for total knee replacement or total hip replacement surgery from admission to discharge: <ul style="list-style-type: none"> semiprivate room and board and general nursing care (private room is covered only when medically necessary) intensive care and other special care units operating, recovery, and treatment rooms anesthesia prescription drugs and supplies used during a covered hospital stay lab and diagnostic imaging Medically necessary outpatient hospital/facility services for total knee replacement or total hip replacement surgery performed on the same day as surgery: <ul style="list-style-type: none"> scheduled surgery/anesthesia lab and diagnostic imaging all other eligible outpatient hospital care related to the scheduled knee or hip replacement surgery provided on the day of surgery 	Members age 18 and older: 80% after you pay deductible when you use Blue Distinction Centers for Knee and Hip Replacement Surgery .	Members age 18 and older: 60% deductible, plus you pay any charges billed to you that exceed the allowed amount when you use an Out-of-Network Participating Provider .
	Members age 17 and younger: 80% after you pay the deductible when you use In-Network Providers .	When you use a Nonparticipating Provider, there is NO COVERAGE . <hr/> Members age 17 and younger: NO COVERAGE.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.
- For professional services related to eligible knee and hip replacement services, refer to Physician Services.
- Blue Distinction Centers® are part of a national designation program that recognizes hospitals that meet the quality-focused criteria that emphasize patient safety and patient outcomes. Blue Distinction Centers+ are part of the national designation program that, in addition to demonstrated expertise in delivering quality specialty care emphasizing patient safety and patient outcomes, are also recognized for their cost efficiency.
- Blue Distinction Centers for Knee and Hip Replacement are designated facilities within participating Blue Plans' service areas that demonstrate an expertise in quality care, resulting in better overall outcomes for patients, by meeting objective measures developed with input for expert physicians and medical organizations. Blue Distinction Centers for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

- As technology changes, the covered knee and hip replacement procedures will be subject to modifications in the form of additions or deletions, when appropriate.
- All requests for prior authorization must be submitted in writing to:

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

- There may be a travel benefit up to a maximum of \$5,000 available for expenses directly related to a preauthorized knee and hip replacement surgery if the patient is age 18 or older who lives more than 50 miles from a Blue Distinction Centers for Knee and Hip Replacement. For more information, please call Customer Service.
- For a list of Blue Distinction Centers for Knee and Hip Replacement visit the Claims Administrator's website or call Customer Service.
- For pre-operative and post-operative knee and hip replacement services, refer to Hospital Inpatient and Hospital Outpatient and Physician Services.
- Out-of-Network Participating Provider means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan but is not in the Blue Distinction Network.

NOT COVERED:

- please refer to the General Exclusions section
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Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Health care professional and hospital/facility charges for: <ul style="list-style-type: none"> delivery postpartum care 	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

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

NOT COVERED:

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

Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds Devices for habilitative and rehabilitative services Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings Insulin pumps, glucometers and related equipment and devices, including diabetic supplies, except as noted below 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 Cataract Surgery or aphakia: <ul style="list-style-type: none"> One frame and one pair of lenses, OR One pair of contact lenses, OR A one-year supply of disposable contact lenses Upgrades to lenses are not eligible for coverage. This includes but is not limited to: tinting, anti-reflective coating, scratch guard, and progressive lenses. Hearing aids and supplies. Certain limits apply, (see NOTES). Cochlear implants 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

<ul style="list-style-type: none"> • Non-investigative bone conductive hearing devices • Scalp/cranial hair prostheses (wigs) provided hair loss is due to alopecia areata or cancer. Maximum of one (1) per person per calendar year. • Foot orthoses when prescribed by a physician • Investigational Medtronic devices 		
<ul style="list-style-type: none"> • Electric or hospital grade breast pumps 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> • Medtronic Minimed insulin pump and related equipment and supplies • GuardianRT® Continuous Glucose Monitoring System and related equipment and supplies • MySentry® remote glucose monitor • Glucose test strips and lancets 	100%	100%

NOTES:

- Coverage for hearing aids is limited to one (1) per ear per person, every three (3) calendar years.
- 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 is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For hearing aid exam services, refer to Physician Services.

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the 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 non-medical 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 workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate

- services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
 - duplicate equipment, prosthetics, or supplies
 - replacement of properly functioning durable medical equipment
 - foot orthoses, except as specified in the Benefit Chart
 - scalp/cranial hair prostheses (wigs) for any diagnosis other than alopecia areata and except when hair loss is due to chemotherapy
 - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
 - devices for maintenance services
 - please refer to the General Exclusions section
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Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Outpatient health care professional charges for services including: <ul style="list-style-type: none"> assessments and diagnostic services individual/group/family therapy (office/in-home mental health services) neuro-psychological examinations Professional health care charges for services including: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> evaluation and diagnostic services individual/group therapy crisis evaluations observation beds family therapy 	<p>100% after you pay the \$20 general practice office visit copay for the office visit charge; 100% for all other eligible services.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>
<ul style="list-style-type: none"> Inpatient health care professional charges Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: <ul style="list-style-type: none"> hospital based partial programs hospital based day treatment hospital based Intensive Outpatient Programs (IOP) all eligible inpatient services emergency holds 	<p>80%</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- 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.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Coverage is provided for counseling and hormone therapy for individuals with gender dysphoria.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Coverage is provided for marriage/couples counseling.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- Coverage provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- For home health related services, refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)
 - custodial care, nonskilled care, adult daycare or personal care attendants
 - services or confinements ordered by a court or law-enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
 - room and board for foster care, group homes, incarceration, shelter care, and lodging programs
 - halfway house services
 - services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
 - educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
 - skills training
 - therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
 - services for the treatment of learning disabilities
 - therapeutic day care and therapeutic camp services
 - hippotherapy (equine movement therapy)
 - please refer to the General Exclusions section
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Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech or language pathologist Therapies 	100% after you pay the \$40 specialist office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Office visits from a physician 	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- Physical therapy is limited to an annual benefit maximum of 50 visits per person, for all networks combined, without prior authorization. This limit is also combined for both professional and facility billed services. Refer to Hospital Outpatient. With prior authorization, additional services may be covered.
- Speech therapy and occupational therapy are limited to an annual benefit maximum of 40 visits per person for each type of service, for all networks combined, without prior authorization. These limits are also combined for both professional and facility billed services. Refer to Hospital Outpatient. With prior authorization, additional services may be covered.
- For lab and diagnostic imaging services billed by a health care professional, refer to Physician Services.
- For hospital/facility charges, refer to Hospital Inpatient or Hospital Outpatient.
- An office visit copay is applied to the evaluation, re-evaluations, therapeutic procedures and assessments not to exceed one (1) copay per visit.
- Office visits may include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.

NOT COVERED:

- services primarily educational in nature, except as specified in the Benefit Chart
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical 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 therapy for the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Physician Services

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Office visits: <ul style="list-style-type: none"> Well@Work Medtronic Online Care E-Visit Telephone consultations Specific services as part of a chronic condition for: <ul style="list-style-type: none"> diabetes hyperlipidemia hypertension such as: <ul style="list-style-type: none"> high blood pressure <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic annual lab services including: 12-lead ECG, urinalysis, fasting blood glucose or A1C, hematocrit, serum sodium, potassium, creatinine, calcium, and lipid profile high cholesterol <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic lab services including: ALT or AST, CPK, fasting lipid panel or lipid panel with direct LDL and transaminase 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Office visit at a retail health clinic (Convenience care) (for services other than the office visit charge, see below): 	100% after you pay the \$10 retail health clinic copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Office visits (for services other than the office visit charge, see below): <ul style="list-style-type: none"> illness 	100% after you pay the \$20 general practice or \$40 specialist office visit copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Professional urgent care services: <ul style="list-style-type: none"> office visit lab and diagnostic imaging all other professional urgent care services 	100% after you pay the \$20 urgent care copay.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

<ul style="list-style-type: none"> • Allergy testing, serum, and injections • Lab and diagnostic imaging, except as noted below • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization (see NOTES) • Assistant surgeon • Bariatric surgery to correct morbid obesity, including: <ul style="list-style-type: none"> ▪ anesthesia ▪ assistant surgeon • Kidney and cornea transplants • Injectable drugs administered by a health care professional • Medical Nutrition therapy 	<p><u>Services in an office:</u></p> <p>100%</p> <p><u>Services in a facility:</u></p> <p>80% after you pay the deductible.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>
<ul style="list-style-type: none"> • Conditional living donor kidney transplants when provided by an approved Mayo Clinic facility (see NOTES) 	<p>80% after you pay the deductible.</p>	<p>NO COVERAGE.</p>
<ul style="list-style-type: none"> • Mobile Cardiac Outpatient Telemetry (MCOT) technical component when billed by Medtronic Mobile Cardiac 	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<ul style="list-style-type: none"> • Health care professional charges for Magnetic Resonance Imaging (MRI) of the breast • Genetic testing for individuals at high risk for breast cancer or ovarian cancer • Hearing aid exams, fittings and adjustments • Palliative care • Specific services as part of a chronic condition when related to a diabetes diagnosis including, but not limited to: <ul style="list-style-type: none"> ▪ office visits (every six (6) months) ▪ annual foot exams and foot care ▪ annual influenza vaccine ▪ cholesterol, triglycerides, plasma glucose, hemoglobin and A1C testing ▪ annual serum creatinine, liver function testing, and micro albuminuria screening ▪ annual eye exam ▪ outpatient self-management training and education, including medical nutrition therapy 	<p>100%</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
 - Eligible Mobile Cardiac Outpatient Telemetry (MCOT) technical component when billed by Medtronic Mobile Cardiac services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
 - The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
 - Specific surgical implants and tubal ligation for elective female sterilization are covered under preventive care. Refer to Preventive Care.
 - For kidney transplants performed in conjunction with an eligible major transplant, 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
 - Travel benefit- (Conditional living donor kidney transplant) Eligible when you travel more than 50 miles to obtain transplant care at an approved Mayo Clinic facility or when the approved Mayo Clinic facility provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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.
 - The Plan covers certain patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
 - Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
 - Online Care E-Visit is a patient initiated, limited on-line evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
 - The retail health clinic copay is waived when services are received at Well@Work Medtronic and for three (3) visits per family per calendar year at any other In-Network retail health clinic.
 - 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. Independent lab services associated with a retail health clinic visit will pay the same as retail health clinic professional lab.
 - The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
 - The Plan covers services related to artificial cervical disc procedures.
 - For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.
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NOT COVERED:

- repair of scars and blemishes on skin surfaces
 - separate charges for pre-operative and post-operative care for surgery
 - internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and, services that would similarly not be charged for an onsite medical office visit, except as specified in the Benefit Chart
 - provider initiated email communications
 - 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
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Prescription Drugs

Participating Pharmacies and Mail Order Program			
Type of Drug	Choice Rx Network Participating Pharmacy	Other In-Network Participating Retail Pharmacies	PrimeMail Mail Order Program
Generic drugs for Diabetes, High Blood Pressure, and Cholesterol	Plan pays 100% when you purchase a 90-day supply through a Choice Rx participating pharmacy or through the Mail Order Program. If you purchase these generic drugs through other participating pharmacies, you can only obtain a 30-day supply and your cost is determined per the schedule below.		
Generic drug copays	For a 34-day supply, you pay \$10 per prescription* For a 90-day supply, you pay \$20 per prescription*	For a 34-day supply, you pay \$15 per prescription* 90-day supply not available	For a 90-day supply you pay \$30 per prescription*
FlexRx preferred brand name drug copay	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$30 minimum and \$60 maximum copayments) For a 90-day supply, you pay \$60*	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$30 minimum and \$60 maximum copayments) 90-day supply not available	For a 90-day supply, you pay \$60*
Non-preferred brand name drug copay	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$50 minimum and \$100 maximum copayments) For a 90-day supply, you pay \$100*	For a 34-day supply, you pay 20% of the participating pharmacy price* (subject to \$50 minimum and \$100 maximum copayments) 90-day supply not available	For a 90-day supply, you pay \$100*
<p>*Or price of the prescription, whichever is less</p> <p>If you get a prescription filled Out-of-Network, coverage is 100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.</p>			
Designated Specialty drugs purchased through a Specialty pharmacy network supplier	<p>For a (1-31 day supply): 20% up to a maximum of \$150</p> <p>For a (32-90 day supply): 20% up to a maximum of \$300</p> <p>Note: The Prime Specialty Pharmacy Network must be used for obtaining specialty drugs. There is no coverage for Out-of-Network Providers.</p>		

The Plan Covers:	Choice Rx Network Participating Pharmacy Other In-Network Participating Retail Pharmacies	Out-of-Network Providers
<ul style="list-style-type: none"> • Prescription drugs (required by Federal law to be dispensed only by prescription of a health care professional who is authorized by law to prescribe the drug) <ul style="list-style-type: none"> ▪ insulin ▪ prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips; needles and syringes; and lancets, except as noted below ▪ prescription injectable drugs that are self-administered and do not require the services of a health care professional, except as noted below ▪ tobacco cessation drugs and products, including over-the-counter tobacco cessation products ▪ oral, transdermal, injectable, intravaginal, and barrier contraceptives for women of reproductive capacity, not otherwise described below ▪ amino acid-based elemental formula ▪ prescription prenatal vitamins ▪ prescription pediatric multivitamins with fluoride ▪ eligible prescription drugs for or related to the treatment of gender dysphoria ▪ designated brand name preventive drugs 	<p>Coverage is 100% after you pay the applicable member cost-sharing shown in the table above.</p>	<p>If you get a prescription filled out-of-network, coverage is 100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.</p>

<ul style="list-style-type: none"> • Benefits are provided for the full range of FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply ▪ Specific emergency contraceptives ▪ Benefits are provided for designated generic preventive drugs with a prescription (such as tobacco cessation drugs and products, aspirin, folic acid, vitamin D, iron, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers of Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. For a current list of designated preventive prescription drugs, contact Customer Service. ▪ For more information regarding contraceptive or preventive prescription drug coverage, visit the Claims Administrator's website. ▪ MySentry® remote glucose monitor ▪ Medtronic Minimed insulin pump and related equipment and supplies ▪ GuardianRT® Continuous Glucose Monitoring System and related equipment and supplies ▪ Diabetic supplies 	100%	100%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> • Prescription drugs administered at the Well@Work Medtronic clinic 	100%	NOT APPLICABLE.
<ul style="list-style-type: none"> • Retail Pharmacy Vaccine Program (see NOTES) 	100% when you present your ID card or otherwise provide notice of coverage at the time of purchase.	NO COVERAGE.

<ul style="list-style-type: none"> Injectable prescription drugs to treat infertility <p>Infertility treatment drugs are subject to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.</p>	<p>100% after you pay the following applicable member cost-sharing:</p> <p><u>For a (1-31 day supply):</u></p> <p>20% up to a maximum of \$150</p> <p><u>For a (32-90 day supply):</u></p> <p>20% up to a maximum of \$300</p>	<p>NO COVERAGE.</p>
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NOTES:

- The advantage to using a Choice Rx network participating pharmacy: Your copayment and/or coinsurance may be lower than if you purchased the drug at a retail pharmacy that is not in the Choice Rx network.
- You can obtain certain generic drugs at no cost if you purchase a 90-day supply through a Choice Rx network participating pharmacy or through the PrimeMail mail-order program. Drugs that qualify for this program are generic medications prescribed for the treatment of diabetes, high blood pressure and cholesterol. If you purchase these generic drugs through a retail pharmacy that is not in the Choice Rx network, your cost-sharing is determined under the regular cost-sharing rules applicable to generic drugs purchased at retail pharmacies.
- The Prescription Drug Plan includes a special network of participating pharmacies known as the Choice Rx network. The Choice Rx network includes: CVS Stores, Walmart stores (including Sam's Club), Kroger stores (including all associated brand names – Kroger, Bakers, CityMarket, Dillons, Fred Meyer, Fry's, Gerbes, JayC, King Soopers, Owens, QFC, Ralphs, Smith's and Pay Less), and the Community Pharmacy RX Network (this is a coalition of independent pharmacies). To locate Choice Rx network participating pharmacies, go to www.bluecrossmn.com/mdt.
- The FlexRx preferred drug list applies to your Plan. For a list of drugs on your specified preferred drug list, visit www.bluecrossmn.com/mdt or contact Customer Service.
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug as well as require payment prior to rendering a service. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.
- The Claims Administrator applies medical management in determining which contraceptives are included on your specified preferred drug list, as well as a subset of contraceptive medications where a \$0 copay applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit the Claims Administrator's website or call Customer Service. If your prescribing health care professional determines that none of the \$0 copay options available under your plan are clinically appropriate for you, he or she may request an exception through the Claims Administrator's website.
- For information regarding contraceptive coverage, please visit the Claims Administrator's website or contact Customer Service.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network out-of-pocket maximum.
- If you choose a brand name drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket maximum, you still pay the difference in cost between the brand name and the generic drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. Certain brand name drugs are not covered when a generic is available. For a list of brand name drugs not covered when a generic is available, visit the Claims Administrator's website or call Customer Service.
- Oral prescription drugs for Infertility treatment are paid at 50% up to the \$15,000 Infertility treatment lifetime maximum for medical services and drugs combined across all health plans sponsored by the Plan Administrator. Refer to Infertility Treatment.
- The Retail Pharmacy Vaccine Program allows you the opportunity to receive certain eligible vaccines at designated pharmacies. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated pharmacies are available at www.bluecrossmn.com/mdt or by contacting Customer Service.

- If you are prescribed a medication subject to step therapy including prescription drugs in the following categories: ARB/RI, Anticonvulsants; Antidepressants; Atopic dermatitis; Atypical antipsychotics; Biologic immunomodulators; GLP-1 receptor agonists; Growth hormones; Insomnia agents; Multiple sclerosis; NSAID/GI protectant; Proton Pump Inhibitors (PPI); Statins; and Zetia, another eligible medication in the same or different drug class must have been prescribed and tried before the medication subject to step therapy will be paid under the drug benefit. Step therapy drug categories are available at the www.bluecrossmn.com/mdt or by contacting Customer Service.
- Specialty drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated Specialty prescription drugs and suppliers is available at www.bluecrossmn.com/mdt or contact Customer Service. Specialty drugs, except for oral infertility drugs are not available through mail order pharmacy.
- Prescription drugs and diabetic supplies are generally covered up to a 90-day supply. You pay one (1) retail copay for a 1-34-day supply and one (1) mail order copay for a 35-90-day supply from a Choice Rx pharmacy. You pay one (1) mail order copay for up to a 90-day supply from a mail order pharmacy. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day.
- Up to 3-cycle supply of self-administered contraceptives not specified above may be purchased at one time for one (1) copay, or for one (1) copay per cycle.
- The Plan will cover prescription tobacco cessation drugs and products and over-the-counter (OTC) tobacco cessation drugs and products with a physician's prescription subject to your copay. Participants in Stop-Smoking Support may use documented enrollment in place of a physician's prescription for OTC tobacco cessation drugs and products. Some quantity limitation may apply.
- When identical chemical entities are from different manufacturers or distributors, the Claims Administrator's Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
- To locate a participating pharmacy in your area, call the pharmacy information telephone number provided in the Customer Service section.
- For prescription drugs dispensed and used during a covered hospital stay, refer to Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, refer to Medical Equipment, Prosthetics and Supplies.
- When you pay for your prescription drugs, insulin and drug therapy supplies yourself, you are required to submit the drug receipt(s) with the claim form for reimbursement.
- The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.

NOT COVERED:

- charges for giving injections that can be self-administered
 - over-the-counter drugs, except as specified in the Benefit Chart
 - investigative or non-FDA approved drugs
 - vitamin or dietary supplements, except as specified in the Benefit Chart
 - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
 - selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
 - please refer to the General Exclusions section
-

Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Preventive care services from professionals, outpatient hospitals/facilities, and medical equipment suppliers included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) for: <ul style="list-style-type: none"> adults infants and children prenatal care The following services when related to a diabetes diagnosis: <ul style="list-style-type: none"> foot care, including, but not limited to the initial and follow-up evaluations of the foot, superficial wound care, debridement and trimming of corns and calluses, and debridement and trimming of the nails cholesterol, hemoglobin and A1C testing vision exams diabetes outpatient self-management training and education, including medical nutrition therapy 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Influenza virus immunization 	100%	100%

NOTES:

- Preventive care services comply with state and federal statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the purchase of a manual breast pump. For electric or hospital grade breast pumps, refer to Medical Equipment, Prosthetics and Supplies.
- The Plan covers surgical implants and tubal ligation for elective female sterilization which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the full range of preventive contraceptive methods and for patient education/counseling for women of reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Refer to Prescription Drugs and Insulin for pharmacy drug coverage.

- Services for complications related to female contraceptive drugs devices, and services for women of reproductive capacity may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Certain vaccines are also covered under the Retail Pharmacy Vaccine Program. Refer to Prescription Drugs and Insulin.
- Adult vision exams are limited to a maximum of one (1) per person per calendar year. Preventive vision exams for dependent children comply with state and federal statutes and regulations and do not apply to this maximum.
- Adult hearing screenings are limited to a maximum of one (1) per person per calendar year. Preventive hearing screenings for dependent children comply with state and federal statutes and regulations and do not apply to this maximum.
- The Plan covers thyroid screening, hemoglobin – CBC, and urinalysis.

NOT COVERED:

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

Reconstructive Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19, including dental implants Elimination or maximum feasible treatment of port wine stains 	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- 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.
- The plan covers orthognathic dental procedures.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis. This benefit may be eligible through you dental coverage.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

NOT COVERED:

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

Skilled Nursing Facility

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">• Skilled care ordered by a physician• Room and board• General nursing care• Prescription drugs used during a covered admission• Physical, occupational, and speech therapy• Take-home prescription drugs	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Coverage is limited to a benefit maximum of 120 days per person per calendar year.

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
-

Substance Abuse Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Outpatient health care professional charges for services including: <ul style="list-style-type: none"> 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 	100% after you pay the \$20 general practice office visit copay for the office visit charge; 100% for all other eligible services.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Inpatient health care professional charges Inpatient hospital/residential behavioral health treatment facility charges 	80%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- 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.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- For home health related services, refer to Home Health Care.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)
- custodial care, non-skilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
- 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
<p>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart – lung • Kidney – pancreas transplant performed simultaneously (SPK) • Liver – deceased donor and living donor • Lung – single or double • Pancreas transplant – deceased donor and living donor segmental <ul style="list-style-type: none"> ▪ Pancreas Transplant Alone (PTA) ▪ Simultaneous Pancreas – Kidney transplant (SPK) ▪ Pancreas transplant After Kidney transplant (PAK) • Small-bowel and small-bowel/liver 	<p>80% of the Transplant Payment Allowance for the transplant admission after you pay the In-Network deductible.</p> <p>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.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p>	<p>NO COVERAGE.</p>

NOTES:

- Kidney transplants when not performed in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Physician Services.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.
- Eligible transplant services provided by Participating Transplant Providers will be paid at the Blue Distinction Centers for Transplant (BDCT) Provider level of benefits when the transplant services are not available at a BDCT Provider.

- Travel benefit - Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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:

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

DEFINITIONS:

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

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

CHP WITH HSA BENEFIT CHART

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

Benefit Features, Limitations, and Maximums

Networks

- In-Network Providers participating with this Plan
- BlueCard PPO Network

Benefit Features

Your Liability

Annual Employer Contribution (HSA Benefit Dollars)

	Elected during OE or hired during Jan. 1 to June 30, 2017	Hired during July 1 to Dec. 31, 2017
• Employee	\$500	\$250
• Employee plus spouse	\$750	\$375
• Employee plus child(ren)	\$750	\$375
• Family	\$1,250	\$625

For additional information regarding the HSA, please refer to the HSA Plan Specifics on page 77.

Deductibles

(per calendar year)

In-Network

Out-of-Network

• Employee	\$1,400	\$2,800
• Employee plus spouse	\$2,800	\$5,600
• Employee plus child(ren)	\$2,800	\$5,600
• Family	\$3,600	\$7,200

Deductibles for the Employee plus spouse, Employee plus child(ren) and Family plans are per family. When more than one person in a family is covered under the same Plan, the Individual deductible does not apply.

Benefit Features

Out-of-Pocket Maximums

(per calendar year and includes the annual employer contribution)

Limitations and Maximums

	<u>In-Network</u>	<u>Out-of-Network</u>
• Employee	\$3,500	\$7,000
• Employee plus spouse	\$7,000	\$14,000
• Employee plus child(ren)	\$7,000	\$14,000
• Family	\$9,000*	\$18,000
*Individual out-of-pocket maximum will not exceed \$7,150		

Out-of-Pocket Maximums for the Employee plus spouse, Employee plus child(ren) and Family Plans are per family. When more than one person in a family is covered under the same Plan, the Individual Out-of-Pocket Maximum does not apply.

The following items are applied toward the out-of-pocket maximum:

1. medical and prescription drug coinsurance; and
2. medical and prescription drug deductible.

The amounts accumulated toward the deductible and out-of-pocket maximum do not cross apply to services provided by both the In-Network Providers and Out-of-Network Providers.

Amounts accumulated toward the In-Network deductible and out-of-pocket maximum do not accumulate toward the Out-of-Network out-of-pocket maximum.

Amounts accumulated toward the Out-of-Network deductible and out-of-pocket maximum do not accumulate toward the In-Network out-of-pocket maximum.

Lifetime Maximums

• Infertility treatment and drugs	\$15,000 per person across all health plans sponsored by the Plan Administrator.
• Orthodontic treatment for TMJ	\$5,000 per person across all health plans sponsored by the Plan Administrator.
• Total benefits paid to all other providers combined	Unlimited

Prescription Drug Coverage

Participating Pharmacies and Mail Order Program			
Type of Drug	Choice Rx Network Participating Pharmacy	Other In-Network Participating Retail Pharmacies	PrimeMail Mail Order Program
Generic drugs for Diabetes, High Blood Pressure, and Cholesterol	Plan pays 100% when you purchase a 90-day supply through a Choice Rx participating pharmacy or through the Mail Order Program. If you purchase these generic drugs through other participating pharmacies, you can only obtain a 30-day supply and your cost is determined per the schedule below.		
Generic drug copays	For a 34-day supply, you pay 20% after deductible For a 90-day supply, you pay 20% after deductible	For a 34-day supply, you pay 20% after deductible 90-day supply not available	For a 90-day supply you pay 20% after deductible
FlexRx preferred brand name drug copay	For a 34-day supply, you pay 20% after deductible For a 90-day supply, you pay 20% after deductible	For a 34-day supply, you pay 20% after deductible 90-day supply not available	For a 90-day supply, you pay 20% after deductible
Non-preferred brand name drug copay	For a 34-day supply, you pay 20% after deductible For a 90-day supply, you pay 20% after deductible	For a 34-day supply, you pay 20% after deductible 90-day supply not available	For a 90-day supply, you pay 20% after deductible
If you get a prescription filled Out-of-Network, coverage is 100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.			
Designated Specialty drugs purchased through a Specialty pharmacy network supplier	For a (1-31 day supply): 20% after deductible For a (32-90 day supply): 20% after deductible Note: The Prime Specialty Pharmacy Network must be used for obtaining specialty drugs. There is no coverage for Out-of-Network Providers.		

HSA PLAN SPECIFICS

Consumer Health Plan Coverage	<p>You are required to enroll in the Medtronic's Consumer Health Plan (CHP) to be eligible to make and/or receive contributions to a Health Savings Account (HSA).</p> <p>The CHP and HSA are sponsored by Medtronic and are administered by Blue Cross and Blue Shield of Minnesota.</p> <p>For details regarding the Consumer Health Plan Coverage, review the summary for that plan.</p>		
What is a Health Savings Account?	<p>An HSA or Health Savings Account is a special tax preferred account established under IRS Code Section 233 that is used to pay medical expenses. There are many financial advantages to owning an HSA, including:</p> <ul style="list-style-type: none">○ Employer contributions and employee pretax contributions via cafeteria plan are not taxable income.○ Post-tax contributions are tax deductible even if you do not itemize deductions on Form 1040.○ You may make tax free withdrawal from your HSA for eligible medical expenses not covered by your plan.○ The interest or other earning on the HSA funds accumulates tax free.○ If, in the future, you are not covered by a High Deductible Health Plan (HDHP) you may still make tax free withdrawals from your account for eligible medical expenses but can no longer contribute to the HSA.○ If you become disabled or reach 65, withdrawals can be made for non-medical reasons without penalty but amounts must be reported as taxable income.		
Maximum Employee and Employer Contributions *2017 HSA Contribution Limits: Single: \$3,400 Family: \$6,750 Both the employee and employer can contribute to the HSA. Your annual contribution limit is based upon your health plan coverage. Meaning, between you and your employer's contribution you cannot exceed the annual indexed amounts.* Participants who are 55 years of age or older can contribute an additional \$1,000 to their HSA. This is referred to as a catch up contribution. Catch up contributions must be made directly to SelectAccount.	Employer Contribution per calendar year:	Elected during Open Enrollment or if hired during 1/1/2017 to 6/30/2017.	You will receive half of the annual amount if you are hired during 7/1/2017 to 12/31/2017.
	Employee only:	\$500	\$250
	Employee plus spouse:	\$750	\$375
	Employee plus child(ren):	\$750	\$375
	Family:	\$1250	\$625

When are Employer Contributions funded to an Employee's HSA	<p>The employer contribution will be made by February 2017, for those who enroll in the CHP during open enrollment. If you are hired after July 1, Medtronic will contribute half of the annual HSA contribution on the first pay period following your plan election.</p> <p>Employees must be in an active status at the time of the Medtronic deposit.</p>
How can I access my HSA dollars	<p>Upon enrollment in the CHP, you will automatically receive a VISA debit card which will give you immediate access to your balance. You can order additional debit cards at no cost for your tax dependents online.</p> <p>If you do not wish to have a debit card, you can choose to submit your out of pocket claims for reimbursement manually or electronically online at bluecrossmn.com/mdt.</p>
Does my HSA balance rollover*? *The employee does not need to continue to participate in the CHP.	<p>Yes, the entire balance rolls over year after year. Meaning, there's no risk to you as the employee on losing your funds.</p>
How much interest does my account earn?	<p>Upon enrollment, your HSA will be automatically defaulted to the Select Saver. This unique plan with additional security offer participants extra peace of mind about their HSA dollars. Deposits in Select Saver are being placed in an FDIC insured bank account at Wells Fargo. Customers have up to \$250,000 of protection with deposits in the Select Saver product. The interest rate associated with the Select Saver is .07%. If you wish to earn more interest you have the option of upgrading to the Premium Saver Account.</p> <p>Please note that any funds moved out of Select Saver and into a self-directed investment account are no longer FDIC insured.</p>
HSA Balance on Termination of Employment	<p>The HSA is owned by the employee. Upon termination the employee will have the option of either keeping their funds at SelectAccount or transferring it to another administrator.</p>
Claims and Appeal Administrator	<p>SelectAccount 3535 Blue Cross Road Eagan, MN 55122-1154 (651) 662-5065 or (800) 859-2144 www.selectaccount.com</p>
Plan Year	January 1 – December 31
Claims Submission Period	There is no time limit on how long you have to submit for reimbursement.
Plan Number	003203

Acupuncture

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Acupuncture services	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Acupuncture has an annual benefit maximum of 12 visits per person all networks combined.

NOT COVERED:

- acupuncture services for the treatment of weight loss or smoking cessation
 - please refer to the General Exclusions section
-

Ambulance

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the conditionMedically 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:

- Eligible services you receive from Out-of-Network Providers apply to the In-Network out-of-pocket maximum.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

NOT COVERED:

- transportation services that are not medically necessary for basic or advanced life support
- transportation services that are mainly for your convenience including costs related to transportation (to a facility that is not the nearest medical facility equipped to treat the condition)
- please refer to the General Exclusions section

Bariatric Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Medically necessary inpatient hospital/facility services for bariatric surgery from admission to discharge <ul style="list-style-type: none"> semiprivate room and board and general nursing care (private room is covered only when medically necessary) intensive care and other special care units operating, recovery, and treatment rooms anesthesia prescription drugs and supplies used during a covered hospital stay lab and diagnostic imaging Medically necessary outpatient hospital/facility services for bariatric surgery: <ul style="list-style-type: none"> scheduled surgery/anesthesia lab and diagnostic imaging all other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery 	<p>Members age 18 and older:</p> <p>80% after you pay the deductible when you use Blue Distinction Centers for Bariatric Surgery.</p> <hr/> <p>Members age 17 and younger:</p> <p>80% after you pay the deductible when you use In-Network Providers.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>
The Plan Covers	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Professional services for bariatric surgery to correct morbid obesity, including: <ul style="list-style-type: none"> anesthesia assistant surgeon 	<p>80% after you pay the deductible for all other eligible services.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.**
- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.
- As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.**

- **All requests for prior authorizations must be submitted in writing to:**

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

- There may be a travel benefit available for expenses directly related to a preauthorized bariatric surgery, if the patient is age 18 or older who lives more than 50 miles from a Blue Distinction Centers for Bariatric Surgery. Eligible benefits are paid at 100 percent up to a maximum of \$2,500 per person per calendar year. For more information, please call Customer Service.
- For a list of Blue Distinction Centers for Bariatric Surgery, call Customer Service or visit the Claims Administrator's website at www.bluecrossmn.com/mdt.
- For pre-operative and post-operative bariatric services, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOT COVERED:

- please refer to the General Exclusions section
-

Chiropractic Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Chiropractic care Manipulations Therapies Other chiropractic services 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Chiropractic care is limited to a benefit maximum of 30 visits per person per calendar year for all networks combined. Lab and diagnostic imaging do not accumulate toward the visit maximum.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical 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 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 therapy to treat the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Dental Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<p>This is not a dental plan. The following limited dental-related coverage is provided:</p> <ul style="list-style-type: none"> Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy, natural teeth including: <ul style="list-style-type: none"> dental implants (see NOTES) Orthodontic services and supplies for the treatment of temporomandibular joint (TMJ) disorder 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19, including: <ul style="list-style-type: none"> dental implants removal of impacted teeth or tooth extractions related orthodontia related oral surgery bone grafts Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder (except as noted above) 	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services, treatment and/or restoration of a sound and healthy, natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy, natural teeth, crowns, fillings and bridges.
- A sound and healthy, natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy, natural tooth.
- Accident-related dental implants are covered only for two (2) of the four (4) teeth: number seven (7), eight (8), number nine (9), and number 10, AND only for two (2) of the four (4) teeth: number 23, number 24, number 25 and number 26.

- The Plan covers anesthesia provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.
- Orthognathic surgery is covered for the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder and accepted medically necessary treatments as determined by the Claims Administrator.
- Orthodontic services and supplies for the treatment of temporomandibular joint disorder and craniomandibular disorder care services have a lifetime benefit maximum of \$5,000 per person.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or dental prosthesis.
- Please note that benefits may be available through your dental coverage.

NOT COVERED:

- all orthodontia, except as specified in the Benefit Chart
 - dental services to treat an injury from biting or chewing
 - dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
 - dental implants and any associated services and/or charges, except as specified in the Benefit Chart
 - removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as specified in the Benefit Chart
 - accident-related dental services initiated after 12 months from the date of injury or 12 months of your effective date of coverage under this Plan or occurring more than 24 months after the date of initial treatment
 - replacement of a damaged dental bridge from an accident-related injury
 - osteotomies and other procedures associated with the fitting of dentures or dental implants, except as specified in the Benefit Chart
 - oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy
 - services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
 - services to treat bruxism, including dental splints
 - please refer to the General Exclusions section
-

Emergency Room

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

NOTES:

- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network out-of-pocket maximum.
- For inpatient services, refer to Hospital Inpatient and Physician Services.
- For urgent care visits, refer to Hospital Outpatient and Physician Services.

NOT COVERED:

- please refer to the General Exclusions section
-

Gender Dysphoria

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Inpatient hospital/facility charges for medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> 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 Outpatient hospital/facility charges for medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> Scheduled surgery/anesthesia lab and diagnostic imaging all other outpatient hospital care Health care professional charges for mental health, medical and surgical treatment of Gender Dysphoria including: <ul style="list-style-type: none"> office visit urgent Care outpatient professional visit E-Visit lab and diagnostic imaging inpatient hospital/facility visits during a covered admission outpatient hospital/facility visits anesthesia by a provider other than the operating or assisting provider surgery assistant surgeon injectable drugs administered by a health care professional services administered by an aesthetician 	80% after you pay the deductible.	80% after you pay the deductible.
<ul style="list-style-type: none"> Prescription drug charges for the treatment of Gender Dysphoria 	For the level of coverage, refer to Prescription Drugs.	For the level of coverage, refer to Prescription Drugs.

NOTES:

- Travel benefit - Eligible when you live more than 50 miles from a provider for gender reassignment surgery.
 - The Plan covers the patient up to \$50 per day for lodging.
 - 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 to the facility.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person per lifetime.
- Prior authorization is required for Gender Dysphoria services. Please see the Notification Requirements section.
- **Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.**
- **Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the World Professional Association for Transgender Health (WPATH) Version 7, may consist of several interventions with the type and sequence of interventions differing from person to person. These include psychological and social interventions, continual experience living in the identity-congruent gender role, treatment with hormones and surgery to change the genitalia and other sex characteristics to that of the identity-congruent gender.**
- **All requests for prior authorization must be submitted in writing to:**

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

Criteria for All Surgical Treatment

- Surgical treatment of gender dysphoria may be considered **MEDICALLY NECESSARY** when **all** of the following criteria have been met. These criteria are based on the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, from the World Professional Association for Transgender Health, Version 7.
3. A comprehensive diagnostic evaluation has been completed by a psychiatrist, a clinical psychologist, or other licensed mental health professional* who:
 - e. Is experienced in the evaluation and treatment of gender dysphoria and
 - f. Has competence in the diagnosis of gender nonconforming identities and expressions, as well as in diagnosing possible comorbid disorders such as psychotic disorders, personality disorders, and substance related disorders.
 - g. Has the ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; and
 - h. Meets the Minnesota Department of Human Services qualifications for a mental health professional, as set forth in Minn.Stat.245.4871, subds. 26 and 27 (2015) and Minn.Stat.245.462, subds. 17 and 18 (2015). Providers outside Minnesota must be appropriately licensed according to applicable state law; **AND**
 4. Based on the comprehensive evaluation, the individual meets the diagnostic criteria for gender dysphoria in adolescents and adults per the *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM 5):
 - c. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration as manifested by **at least two** of the following:
 - vii. A marked incongruence between one's experienced/expressed gender and primary and/or

- secondary sex characteristics.
- viii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
- ix. A strong desire for the primary and/or secondary sex characteristics of the other gender.
- x. A strong desire to be the other gender (or some alternative gender different from one's assigned gender).
- xi. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- xii. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

AND

- d. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Breast surgery

- Mastectomy and creation of a male chest in female-to-male members may be considered **MEDICALLY NECESSARY** when the criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota). Requests for breast surgery for a member younger than 18 years of age will be reviewed by medical director; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled.
 - **NOTE: Hormone therapy is not a prerequisite for mastectomy for female-to-male members.** The *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* Version 7 from the World Professional Association for Transgender Health (WPATH) state the following: "Chest surgery in FtM (female-to-male) patients could be carried out (before age of majority) preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."
- Breast augmentation (e.g. implants/lipofilling) may be considered **MEDICALLY NECESSARY** in male-to-female members when criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota). Requests for breast surgery for a member younger than 18 years of age will be reviewed by medical director; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled.
 - **NOTE: Hormone therapy is not a prerequisite for breast augmentation for male-to-female members.** The *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* Version 7 from the World Professional Association for Transgender Health (WPATH) state the following: "Although not an explicit criterion, it is recommended that MtF (male-to-female) patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results."

2. Documentation Requirements:

- a. One letter of recommendation must be provided to a health plan representative from a qualified mental health professional. The letter must address **all** of the following:
 - i. The member's general identifying characteristics; and

- ii. Results of the member's psychosocial assessment, including any diagnoses; and
- iii. The duration of the mental health professional's relationship with the member including the type of evaluation and therapy or counseling to date; and
- iv. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; and
- v. A statement about the fact that informed consent has been obtained from the patient; and
- vi. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
- vii. The health plan and the physician responsible for breast removal or augmentation must receive this letter and recommendations for surgery and the surgical treatment must be authorized by the health plan prior to its occurrence. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the member's chart.

Genital surgery

- Hysterectomy and salpingo-oophorectomy in female-to-male members and orchiectomy in male-to-female members may be considered **MEDICALLY NECESSARY** when the criteria in section I **and** the following criteria are met:
 - The member is at least 18 years of age (legal age of majority in Minnesota); and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
 - The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals, unless hormones are not clinically indicated for the individual.
- Metoidioplasty or phalloplasty in female-to-male members and vaginoplasty in male-to-female members may be considered **MEDICALLY NECESSARY** when criteria in section I **and** the following criteria are met:
 - The member is 18 years of age or older; and
 - Persistent, well-documented gender dysphoria; and
 - Capacity to make a fully informed decision and to give consent to treatment; and
 - If significant medical or mental health concerns are present, they must be reasonably well-controlled; and
 - The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals, unless hormones are not clinically indicated for the individual; and
 - The member has completed 12 continuous months of living in a gender role that is congruent with their gender identity.
- Documentation Requirements
 - Two letters of recommendation from licensed mental health professionals have been obtained; one must be from a licensed doctoral level clinical psychologist or a psychiatrist.
 - Both letters must include all of the information listed in the Documentation Requirements 1-6, above, in section II.
 - These letters must be presented to the health plan and to the surgeon prior to genital surgery. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the patient's chart.

Overview of typical Surgical Procedures for the Treatment of Patients with Gender Dysphoria from the World Professional Association for Transgender Health Standards of Care, version 7

- For the Male-to-Female (MtF) Patient, Surgical Procedures may include the following:
 - Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
 - Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
 - Nongenital, nonbreast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, hair removal, and various aesthetic procedures.

- For the Female-to-Male (FtM) Patient, Surgical Procedures may include the following:
 - Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
 - Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;
 - Nongenital, nonbreast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.
- Typical surgical procedures for the Treatment of Patients with Gender Dysphoria are covered if they are determined to be Medically Necessary by the patient's psychiatrist, psychologist, or other licensed mental health professional who is experienced in the evaluation and treatment of gender dysphoria and part of a comprehensive treatment plan;
- Medically necessary facial and pre-surgical genital hair removal by electrolysis or laser performed by a licensed aesthetician is covered under the health plan.

The treatment of children and adolescents with Gender Dysphoria

- The assessment and treatment of children and adolescents with Gender Dysphoria follows the WPATH Standards of Care v7, including the specific competency requirements of mental health professionals working with children or adolescents with Gender Dysphoria;
- The plan covers fully reversible physical interventions for adolescents involving the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty;
- Two goals justify intervention with puberty-suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment;
- Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

Criteria for Puberty-Suppressing Hormones

- In order for adolescents to receive puberty-suppressing hormones, the following minimum criteria must be met:
 1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
 2. Gender dysphoria emerged or worsened with the onset of puberty;
 3. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
 4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
- Risks of Withholding Medical Treatment for Adolescents;
- Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

(WPATH Standards of Care, version 7)

- Preventive health screening guidelines developed for the general population are appropriate for transgender persons for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy.

- Gender-specific preventive services are also necessary for transgender persons appropriate to their anatomy.
 - Examples include the following:
 - Routine Pap smears should be performed as recommended if cervical tissue is present in female-to-male transgender persons;
 - If mastectomy is not performed, mammograms should be performed as recommended.
 - Male-to-female transgender persons treated with estrogen should follow the same screening guidelines for breast cancer as those for all women;
 - Screening for prostate cancer should be performed as recommended for those persons who have retained their prostate.
-

Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to: <ul style="list-style-type: none"> ▪ intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> - licensed registered nurse - licensed practical nurse ▪ services provided by a medical technologist ▪ services provided by a licensed dietitian ▪ services provided by a respiratory therapist ▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services of a home health aide or 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 ▪ prescription drugs 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Coverage is limited to a benefit maximum of 40 visits per person per calendar year.
- Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other preapproved home health care agency consists of up to two (2) consecutive hours per date of service.
- The one (1) home health care visit following early maternity discharge does not apply to the 40-visit maximum.
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For supplies and durable medical equipment billed by a Home Health Agency, refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. Refer to Physician Services.

NOT COVERED:

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care- refer to Skilled nursing care - extended hours, Skilled nursing care - intermittent hours, and Skilled care in the Glossary of Common Terms section
- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section

Home Infusion Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Home infusion therapy services when ordered by a physician • Solutions and pharmaceutical additives and dispensing services • Durable medical equipment • Ancillary medical supplies • Nursing services to: <ul style="list-style-type: none"> ▪ train you or your caregiver ▪ monitor your home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

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
- investigative or non-FDA approved drugs, except as required by law
- please refer to the General Exclusions section

Hospice Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice, including:<ul style="list-style-type: none">routine home carecontinuous home careinpatient respite caregeneral inpatient care	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- 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.
- Coverage for inpatient respite care is for the relief of the patient's primary caregiver and is limited to not more than five (5) consecutive days at a time up to a maximum of 15 days during the episode of hospice care.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

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

Hospital Inpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Room and board and general nursing care 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 Take-home prescription drugs Palliative care 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Conditional living donor kidney transplants when provided by an approved Mayo Clinic facility 	80% after you pay the deductible.	NO COVERAGE.

NOTES:

- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major transplant or 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 provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.
- Travel benefit- (Conditional living donor kidney transplant) Eligible when you travel more than 50 miles to obtain transplant care at an approved Mayo Clinic facility or when the approved Mayo Clinic facility provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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.
- The Plan covers services related to artificial cervical disc procedures.

- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- For hospital/facility charges for bariatric surgery, refer to Bariatric Surgery.
- For hospital/facility charges for knee and hip replacement surgery, refer to Knee and Hip Replacement Surgery.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

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
 - services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care
 - please refer to the General Exclusions section
-

Hospital Outpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Facility urgent care services 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Scheduled surgery/anesthesia Radiation and chemotherapy Kidney dialysis Respiratory therapy Lab and diagnostic imaging, including urgent care lab and diagnostic imaging, except as noted below Medical nutrition therapy Physical, occupational, and speech therapy Palliative care Take-home prescription drugs All other outpatient hospital care, except as noted below 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Magnetic Resonance Imaging (MRI) of the breast 	100% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Genetic testing for individuals at high risk for breast cancer or ovarian cancer Specific services as part of a chronic condition when related to a diabetes diagnosis including, but not limited to: <ul style="list-style-type: none"> office visits (every six (6) months) annual foot exams and foot care annual influenza vaccine cholesterol, triglycerides, plasma glucose, hemoglobin and A1C testing annual serum creatinine, liver function testing, and micro albuminuria screening annual eye exam outpatient self-management training and education, including medical nutrition therapy 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

<ul style="list-style-type: none"> Specific services as part of a chronic condition for: <ul style="list-style-type: none"> diabetes hyperlipidemia hypertension such as: <ul style="list-style-type: none"> high blood pressure <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic annual lab services including: 12-lead ECG, urinalysis, fasting blood glucose or A1C, hematocrit, serum sodium, potassium, creatinine, calcium, and lipid profile high cholesterol <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic lab services including: ALT or AST, CPK, fasting lipid panel or lipid panel with direct LDL and transaminase 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
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NOTES:

- Physical therapy is limited to an annual benefit maximum of 50 visits per person, for all networks combined, without prior authorization. This limit is also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- Speech therapy and occupational therapy are limited to an annual benefit maximum of 40 visits per person for each type of service, for all networks combined, without prior authorization. These limits are also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- The Plan covers anesthesia provided by a licensed professional who is not rendering dental services and inpatient and outpatient hospital charges when necessary to provide dental care 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. Dental services are not covered unless otherwise noted.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- For hospital/facility charges for bariatric surgery, refer to Bariatric Surgery.
- For hospital/facility charges for knee and hip replacement surgery, refer to Knee and Hip Replacement Surgery.
- The Plan covers services related to artificial cervical disc procedures.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

NOT COVERED:

- please refer to the General Exclusions section

Infertility Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Artificial insemination (AI) and intrauterine insemination (IUI) procedures Non-investigative assisted reproductive technologies (ART), procedures and supplies when ordered by a board-certified or board-eligible reproductive endocrinology physician, and furnished in a medical facility approved by the Claims Administrator as a provider of ART services and supplies. No benefits are paid at facilities other than those approved by the Claims Administrator. No benefits are paid for services the Claims Administrator determines are not medically necessary. Embryo freezing and storage (up to 24 months) for embryos produced from one (1) cycle for a member who will undergo cancer treatment that is expected to render them infertile Related services and supplies Physician administered infertility drugs in the office 	80% after you pay the deductible to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.
<ul style="list-style-type: none"> Self-administered injectable prescription drugs to treat infertility dispensed by a retail pharmacy 	80% after you pay the deductible. Up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.	NO COVERAGE.
<ul style="list-style-type: none"> Oral prescription drugs to treat infertility dispensed by a retail pharmacy 	50% after you pay the deductible up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.	50%, plus you pay any charges billed to you that exceed the allowed amount up to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.
<ul style="list-style-type: none"> Take-home prescription drugs 	For the level of coverage, refer to Prescription Drugs.	For the level of coverage, refer to Prescription Drugs.

NOTES:

- The \$15,000 lifetime maximum for Infertility treatment and drugs is for all networks combined across all health plans sponsored by the Plan Administrator.
- One (1) embryo may be implanted per person per cycle.
- A cycle is defined as one (1) partial or complete fertilization attempt extending through the implantation phase only.

- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.

NOT COVERED:

- services for infertility treatments when the number of embryos implanted exceeds one (1)
 - services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
 - donor ova or sperm
 - services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
 - services/charges for or related to physician dispensed self-administered prescription drugs
 - services and prescription drugs for or related to gender selection services
 - please refer to the General Exclusions section
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Knee and Hip Replacement Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Medically necessary inpatient hospital/facility services for total knee replacement or total hip replacement surgery from admission to discharge: <ul style="list-style-type: none"> semiprivate room and board and general nursing care (private room is covered only when medically necessary) intensive care and other special care units operating, recovery, and treatment rooms anesthesia prescription drugs and supplies used during a covered hospital stay lab and diagnostic imaging Medically necessary outpatient hospital/facility services for total knee replacement or total hip replacement surgery performed on the same day as surgery: <ul style="list-style-type: none"> scheduled surgery/anesthesia lab and diagnostic imaging all other eligible outpatient hospital care related to the scheduled knee or hip replacement surgery provided on the day of surgery 	Members age 18 and older: 80% after you pay the deductible when you use Blue Distinction Centers for Knee and Hip Replacement Surgery .	Members age 18 and older: 60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount when you use an Out-of-Network Participating Provider .
	Members age 17 and younger: 80% after you pay the deductible when you use In-Network Providers .	When you use a Nonparticipating Provider, there is NO COVERAGE . <hr/> Members age 17 and younger: NO COVERAGE.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.
- For professional services related to eligible knee and hip replacement services, refer to Physician Services.
- Blue Distinction Centers® are part of a national designation program that recognizes hospitals that meet the quality-focused criteria that emphasize patient safety and patient outcomes. Blue Distinction Centers+ are part of the national designation program that, in addition to demonstrated expertise in delivering quality specialty care emphasizing patient safety and patient outcomes, are also recognized for their cost efficiency.
- Blue Distinction Centers for Knee and Hip Replacement are designated facilities within participating Blue Plans' service areas that demonstrate an expertise in quality care, resulting in better overall outcomes for patients, by meeting objective measures developed with input for expert physicians and medical organizations. Blue Distinction Centers for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

- As technology changes, the covered knee and hip replacement procedures will be subject to modifications in the form of additions or deletions, when appropriate.
- All requests for prior authorization must be submitted in writing to:

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

- There may be a travel benefit up to a maximum of \$5,000 available for expenses directly related to a preauthorized knee and hip replacement surgery if the patient is age 18 or older who lives more than 50 miles from a Blue Distinction Centers for Knee and Hip Replacement. For more information, please call Customer Service.
- For a list of Blue Distinction Centers for Knee and Hip Replacement visit the Claims Administrator's website or call Customer Service.
- For pre-operative and post-operative knee and hip replacement services, refer to Hospital Inpatient and Hospital Outpatient and Physician Services.
- Out-of-Network Participating Provider means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan but is not in the Blue Distinction Network.

NOT COVERED:

- please refer to the General Exclusions section
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Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Health care professional and hospital/facility charges for: <ul style="list-style-type: none"> delivery postpartum care 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

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

NOT COVERED:

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

Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds Devices for habilitative and rehabilitative services Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings Insulin pumps, glucometers and related equipment and devices, including diabetic supplies, except as noted below 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 Cataract Surgery or aphakia: <ul style="list-style-type: none"> One frame and one pair of lenses, OR One pair of contact lenses, OR A one-year supply of disposable contact lenses Hearing aids and supplies. Certain limits apply, (see NOTES) Cochlear implants Non-investigative bone conductive hearing devices Scalp/cranial hair prostheses (wigs) provided hair loss is due to alopecia areata or cancer. Maximum of one (1) per person per calendar year. Foot orthoses when prescribed by a physician Investigational Medtronic devices 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Electric or hospital grade breast pumps 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Medtronic Minimed insulin pump and related equipment and supplies GuardianRT® Continuous Glucose Monitoring System and related equipment and supplies 	100% after you pay the deductible.	100% after you pay the deductible.

<ul style="list-style-type: none"> • MySentry® remote glucose monitor • Glucose test strips and lancets 		
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NOTES:

- Coverage for hearing aids is limited to one (1) per ear per person, every three (3) calendar years.
- Coverage for hearing aid batteries is limited to four (4) units per person per calendar year.
- 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.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- For hearing aid exam services, refer to Physician Services.

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the 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 non-medical 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 workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
- duplicate equipment, prosthetics, or supplies
- replacement of properly functioning durable medical equipment
- foot orthoses, except as specified in the Benefit Chart
- scalp/cranial hair prostheses (wigs) for any diagnosis other than alopecia areata and except when hair loss is due to chemotherapy
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- devices for maintenance services
- please refer to the General Exclusions section

Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Outpatient health care professional charges for services including: <ul style="list-style-type: none"> ▪ assessments and diagnostic services ▪ individual/group/family therapy (office/in-home mental health services) ▪ neuro-psychological examinations • Professional health care charges for services including: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy • Inpatient health care professional charges • Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: <ul style="list-style-type: none"> ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based Intensive Outpatient Programs (IOP) ▪ all eligible inpatient services ▪ emergency holds 	<p>80% after you pay the deductible.</p>	<p>60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- 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.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Coverage is provided for counseling and hormone therapy for individuals with gender dysphoria.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Coverage is provided for marriage/couples counseling.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- Coverage provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- For home health related services, refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)
 - custodial care, nonskilled care, adult daycare or personal care attendants
 - services or confinements ordered by a court or law-enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
 - room and board for foster care, group homes, incarceration, shelter care, and lodging programs
 - halfway house services
 - services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
 - educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
 - skills training
 - therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
 - services for the treatment of learning disabilities
 - therapeutic day care and therapeutic camp services
 - hippotherapy (equine movement therapy)
 - please refer to the General Exclusions section
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Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech or language pathologist Therapies, certain limits apply, (see NOTES). 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Office visits from a physician 	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- Physical therapy is limited to an annual benefit maximum of 50 visits per person, for all networks combined, without prior authorization. This limit is also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- Speech therapy and occupational therapy are limited to an annual benefit maximum of 40 visits per person for each type of service, for all networks combined, without prior authorization. These limits are also combined for both professional and facility billed services. With prior authorization, additional services may be covered.
- For lab and diagnostic imaging services billed by a health care professional, refer to Physician Services.
- For hospital/facility charges, refer to Hospital Inpatient or Hospital Outpatient.
- Office visits may include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.

NOT COVERED:

- services primarily educational in nature, except as specified in the Benefit Chart
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical 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, except as specified in the Benefit Chart
- 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 therapy for the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Physician Services

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Office visits: <ul style="list-style-type: none"> Well@Work Medtronic Online Care E-Visit Retail health clinic (Convenience care) Telephone consultations 	100% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Office visits for illness Urgent care office visits Allergy testing, serum, and injections Lab and diagnostic imaging, except as noted Inpatient hospital/facility visits during a covered admission Outpatient hospital/facility visits Anesthesia by a provider other than the operating, delivering, or assisting provider Surgery, including circumcision and sterilization (see NOTES) Assistant surgeon Bariatric surgery to correct morbid obesity, including Anesthesia Assistant surgeon Kidney and cornea transplants Injectable drugs administered by a health care professional Hearing aid exams, fittings and adjustments Palliative care 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Conditional living donor kidney transplants when provided by an approved Mayo Clinic facility (see NOTES) 	80% after you pay the deductible.	NO COVERAGE.
<ul style="list-style-type: none"> Mobile Cardiac Outpatient Telemetry (MCOT) technical component when billed by Medtronic Mobile Cardiac 	80% after you pay the deductible.	80% after you pay the deductible.

<ul style="list-style-type: none"> Health care professional charges for Magnetic Resonance Imaging (MRI) of the breast 	100% after deductible	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Genetic testing for individuals at high risk for breast cancer or ovarian cancer Specific services as part of a chronic condition when related to a diabetes diagnosis including, but not limited to: <ul style="list-style-type: none"> office visits (every six (6) months) annual foot exams and foot care annual influenza vaccine cholesterol, triglycerides, plasma glucose, hemoglobin and A1C testing annual serum creatinine, liver function testing, and micro albuminuria screening annual eye exam outpatient self-management training and education, including medical nutrition therapy 	100%	
<ul style="list-style-type: none"> Specific services as part of a chronic condition for: <ul style="list-style-type: none"> diabetes hyperlipidemia hypertension such as: <ul style="list-style-type: none"> high blood pressure <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic annual lab services including: 12-lead ECG, urinalysis, fasting blood glucose or A1C, hematocrit, serum sodium, potassium, creatinine, calcium, and lipid profile high cholesterol <ul style="list-style-type: none"> outpatient self-management training outpatient diagnostic lab services including: ALT or AST, CPK, fasting lipid panel or lipid panel with direct LDL and transaminase 		

NOTES:

- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Eligible Mobile Cardiac Outpatient Telemetry (MCOT) technical component when billed by Medtronic Mobile Cardiac services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- Specific surgical implants for elective female sterilization are covered under preventive care. Refer to Preventive Care.
- For kidney transplants performed in conjunction with an eligible major transplant, 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
- Travel benefit- (Conditional living donor kidney transplant) Eligible when you travel more than 50 miles to obtain transplant care at an approved Mayo Clinic facility or when the approved Mayo Clinic facility provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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.
- The Plan covers certain patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- Online Care E-Visit is a patient initiated, limited on-line evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- The coinsurance and deductible are waived when services are received at Well@Work Medtronic and for three (3) visits per family per calendar year at any other In-Network retail health clinic.
- 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. Independent lab services associated with a retail health clinic visit will pay the same as retail health clinic professional lab.
- The Plan covers palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers services related to artificial cervical disc procedures.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
 - separate charges for pre-operative and post-operative care for surgery
 - internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and, services that would similarly not be charged for an onsite medical office visit, except as specified in the Benefit Chart
 - provider initiated email communications
 - 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

Participating Pharmacies and Mail Order Program			
Type of Drug	Choice Rx Network Participating Pharmacy	Other In-Network Participating Retail Pharmacies	PrimeMail Mail Order Program
Generic drugs for Diabetes, High Blood Pressure, and Cholesterol	Plan pays 100% after deductible when you purchase a 90-day supply through a Choice Rx participating pharmacy or through the Mail Order Program. If you purchase these generic drugs through other participating pharmacies, you can only obtain a 30-day supply and your cost is determined per the schedule below.		
Generic drug copays	You owe 20% after you pay the deductible		
FlexRx preferred brand name drug copay	You owe 20% after you pay the deductible		
Non-preferred brand name drug copay	You owe 20% after you pay the deductible		
Designated Specialty drugs purchased through a Specialty pharmacy network supplier	You owe 20% after you pay the deductible		

The Plan Covers:	Choice Rx Network Participating Pharmacy Other In-Network Participating Retail Pharmacies	Out-of-Network Providers
<ul style="list-style-type: none"> Prescription drugs (required by Federal law to be dispensed only by prescription of a health care professional who is authorized by law to prescribe the drug) <ul style="list-style-type: none"> insulin prescription injectable drugs that are self-administered and do not require the services of a health care professional, except as noted below amino acid-based elemental formula prescription pediatric multivitamins with fluoride eligible prescription drugs for or related to the treatment of gender dysphoria 	80% after deductible	If you get a prescription filled out-of-network, coverage is 80% after deductible, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.
<ul style="list-style-type: none"> Benefits are provided for the full range of FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. <ul style="list-style-type: none"> Specific emergency contraceptives Benefits are provided for designated generic preventive drugs with a prescription (such as tobacco cessation drugs and products, aspirin, folic acid, vitamin D, iron, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers of Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. For a current list of designated preventive prescription drugs, contact Customer Service. 	100%	100%, plus you pay any charges billed to you that exceed the allowed amount.

<ul style="list-style-type: none"> • Prescription drugs administered at the Well@Work Medtronic clinic • MySentry® remote glucose monitor • Medtronic Minimed insulin pump and related equipment and supplies • GuardianRT® Continuous Glucose Monitoring System and related equipment and supplies • Diabetic supplies 	100% after the deductible	NOT APPLICABLE.
<ul style="list-style-type: none"> • Retail Pharmacy Vaccine Program (see NOTES) 	100% when you present your ID card or otherwise provide notice of coverage at the time of purchase.	NO COVERAGE.
<ul style="list-style-type: none"> • Injectable prescription drugs to treat infertility <p>Infertility treatment drugs are subject to a lifetime benefit maximum of \$15,000 per person for treatment and drugs combined across all health plans sponsored by the Plan Administrator.</p>	80% after the deductible	NO COVERAGE.

NOTES:

- The advantage to using a Choice Rx network participating pharmacy: Your copayment and/or coinsurance may be lower than if you purchased the drug at a retail pharmacy that is not in the Choice Rx network.
- You can obtain certain generic drugs at no cost if you purchase a 90-day supply through a Choice Rx network participating pharmacy or through the PrimeMail mail-order program. Drugs that qualify for this program are generic medications prescribed for the treatment of diabetes, high blood pressure and cholesterol. If you purchase these generic drugs through a retail pharmacy that is not in the Choice Rx network, your cost-sharing is determined under the regular cost-sharing rules applicable to generic drugs purchased at retail pharmacies.
- The Prescription Drug Plan includes a special network of participating pharmacies known as the Choice Rx network. The Choice Rx network includes: CVS Stores, Walmart stores (including Sam's Club), Kroger stores (including all associated brand names – Kroger, Bakers, CityMarket, Dillons, Fred Meyer, Fry's, Gerbes, JayC, King Soopers, Owens, QFC, Ralphs, Smith's and Pay Less), and the Community Pharmacy RX Network (this is a coalition of independent pharmacies). To locate Choice Rx network participating pharmacies, go to www.bluecrossmn.com/mdt.
- The FlexRx preferred drug list applies to your Plan. For a list of drugs on your specified preferred drug list, visit www.bluecrossmn.com/mdt or contact Customer Service.
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug as well as require payment prior to rendering a service. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.
- The Claims Administrator applies medical management in determining which contraceptives are included on your specified preferred drug list, as well as a subset of contraceptive medications where a \$0 copay applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit the Claims Administrator's website or call Customer Service. If your prescribing health care professional determines that none of the \$0 copay options available under your plan are clinically appropriate for you, he or she may request an exception through the Claims Administrator's website.
- For information regarding contraceptive coverage, please visit the Claims Administrator's website or contact Customer Service.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network out-of-pocket maximum.

- If you choose a brand name drug when there is an equivalent generic drug, you will also pay the difference in cost between the brand name and the generic drug, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket maximum, you still pay the difference in cost between the brand name and the generic drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. Certain brand name drugs are not covered when a generic is available. For a list of brand name drugs not covered when a generic is available, visit the Claims Administrator's website or call Customer Service.
- Oral prescription drugs for Infertility treatment are paid at 50% up to the \$15,000 Infertility treatment lifetime maximum for medical services and drugs combined across all health plans sponsored by the Plan Administrator. Refer to Infertility Treatment.
- The Retail Pharmacy Vaccine Program allows you the opportunity to receive certain eligible vaccines at designated pharmacies. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated pharmacies are available at www.bluecrossmn.com/mdt or by contacting Customer Service.
- If you are prescribed a medication subject to step therapy including prescription drugs in the following categories: ARB/RI, Anticonvulsants; Antidepressants; Atopic dermatitis; Atypical antipsychotics; Biologic immunomodulators; GLP-1 receptor agonists; Growth hormones; Insomnia agents; Multiple sclerosis; NSAID/GI protectant; Proton Pump Inhibitors (PPI); Statins; and Zetia, another eligible medication in the same or different drug class must have been prescribed and tried before the medication subject to step therapy will be paid under the drug benefit. Step therapy drug categories are available at the www.bluecrossmn.com/mdt or by contacting Customer Service.
- Specialty drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated Specialty prescription drugs and suppliers is available at www.bluecrossmn.com/mdt or contact Customer Service. Specialty drugs, except for oral infertility drugs are not available through mail order pharmacy.
- Prescription drugs and diabetic supplies are generally covered up to a 90-day supply. You pay one (1) retail copay for a 1-34-day supply and one (1) mail order copay for a 35-90-day supply from a Choice Rx pharmacy. You pay one (1) mail order copay for up to a 90-day supply from a mail order pharmacy. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day.
- Up to 3-cycle supply of self-administered contraceptives not specified above may be purchased at one time for one (1) copay, or for one (1) copay per cycle.
- The Plan will cover prescription tobacco cessation drugs and products and over-the-counter (OTC) tobacco cessation drugs and products with a physician's prescription subject to your copay. Participants in Stop-Smoking Support may use documented enrollment in place of a physician's prescription for OTC tobacco cessation drugs and products. Some quantity limitation may apply.
- When identical chemical entities are from different manufacturers or distributors, the Claims Administrator's Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.
- To locate a participating pharmacy in your area, call the pharmacy information telephone number provided in the Customer Service section.
- For prescription drugs dispensed and used during a covered hospital stay, refer to Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, refer to Medical Equipment, Prosthetics and Supplies.
- When you pay for your prescription drugs, insulin and drug therapy supplies yourself, you are required to submit the drug receipt(s) with the claim form for reimbursement.
- The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.

NOT COVERED:

- charges for giving injections that can be self-administered
 - over-the-counter drugs, except as specified in the Benefit Chart
 - investigative or non-FDA approved drugs
 - vitamin or dietary supplements, except as specified in the Benefit Chart
 - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
 - selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
 - please refer to the General Exclusions section
-

Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Preventive care services from professionals, outpatient hospitals/facilities, and medical equipment suppliers included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) for: <ul style="list-style-type: none"> adults infants and children prenatal care The following services when related to a diabetes diagnosis: <ul style="list-style-type: none"> foot care, including, but not limited to the initial and follow-up evaluations of the foot, superficial wound care, debridement and trimming of corns and calluses, and debridement and trimming of the nails cholesterol, hemoglobin and A1C testing vision exams diabetes outpatient self-management training and education, including medical nutrition therapy 	100%	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> Influenza virus immunization 	100%	100%

NOTES:

- Preventive care services comply with state and federal statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the purchase of a manual breast pump within. For electric or hospital grade breast pumps, refer to Medical Equipment, Prosthetics and Supplies.
- The Plan covers surgical implants and tubal ligation for elective female sterilization which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage, please visit the Claims Administrator's website or contact Customer Service.

- The Plan covers the full range of preventive contraceptive methods and for patient education/counseling for women of reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Refer to Prescription Drugs and Insulin for pharmacy drug coverage.
- Services for complications related to female contraceptive drugs, devices, and services for women of reproductive capacity may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- Certain vaccines are also covered under the Retail Pharmacy Vaccine Program. Refer to Prescription Drugs and Insulin.
- Adult vision exams are limited to a maximum of one (1) per person per calendar year. Preventive vision exams for dependent children comply with state and federal statutes and regulations and do not apply to this maximum.
- Adult hearing screenings are limited to a maximum of one (1) per person per calendar year. Preventive hearing screenings for dependent children comply with state and federal statutes and regulations and do not apply to this maximum.
- The Plan covers thyroid screening, hemoglobin – CBC, and urinalysis.

NOT COVERED:

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

Reconstructive Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19, including dental implants Elimination or maximum feasible treatment of port wine stains 	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.

NOTES:

- 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.
- The plan covers orthognathic dental procedures.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis. This benefit may be eligible through you dental coverage.
- For gender dysphoria treatment and related services, refer to Gender Dysphoria Treatment.

NOT COVERED:

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

Skilled Nursing Facility

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">• Skilled care ordered by a physician• Room and board• General nursing care• Prescription drugs used during a covered admission• Physical, occupational, and speech therapy• Take-home prescription drugs	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Coverage is limited to a benefit maximum of 120 days per person per calendar year.

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
-

Substance Abuse Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Outpatient health care professional charges for services including: <ul style="list-style-type: none"> assessment and diagnostic services family therapy opioid treatment Outpatient hospital/outpatient behavioral health treatment facility charges for services including Intensive Outpatient Programs (IOP) and related aftercare services Inpatient health care professional charges Inpatient hospital/residential behavioral health treatment facility charges 	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- 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.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- For home health related services, refer to Home Health Care.

NOT COVERED:

- services for substance abuse or addictions not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)
- custodial care, non-skilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
- 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
<p>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart – lung • Kidney – pancreas transplant performed simultaneously (SPK) • Liver – deceased donor and living donor • Lung – single or double • Pancreas transplant – deceased donor and living donor segmental <ul style="list-style-type: none"> ▪ Pancreas Transplant Alone (PTA) ▪ Simultaneous Pancreas – Kidney transplant (SPK) ▪ Pancreas transplant After Kidney transplant (PAK) • Small-bowel and small-bowel/liver 	<p>80% of the Transplant Payment Allowance for the transplant admission after you pay the deductible.</p> <p>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.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p>	<p>NO COVERAGE.</p>

NOTES:

- Kidney transplants when not performed in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Physician Services.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.
- Eligible transplant services provided by Participating Transplant Providers will be paid at the Blue Distinction Centers for Transplant (BDCT) Provider level of benefits when the transplant services are not available at a BDCT Provider.

- Travel benefit - Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
 - The Plan covers a companion/caregiver up to \$50 per day for lodging.
 - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
 - Total eligible benefits are paid at 100 percent and shall not exceed \$5,000 per person 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:

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

DEFINITIONS:

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

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

**The following sections apply to the
Medtronic PPO and CHP with HSA
Medical Plans specified in this SPD.**

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatments, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except as specified in the Benefit Chart.
3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Charts.
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. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost sharing amount (including, for example, deductibles, copayments, and coinsurance) described in this Plan.
7. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a worker's compensation claim.
8. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g. homeowner's insurance, boat owner's insurance, liability insurance) that is payable without regard to fault including charges for service that are applied toward any deductible, copay or coinsurance requirement of such a policy.
9. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
10. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.
11. Services to treat illnesses/injuries that occur while on military duty and are recognized by the Veterans Administration as services related to service-connected illnesses/injuries.
12. Services for dependents if you have employee-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 Charts.
17. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Charts.
18. Services for or related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
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) offenses; 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, shelter care and lodging programs, halfway house services, and skills training.
22. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.
23. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).
24. Services for or related to substance abuse or addictions not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
25. 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 the affected person with the intent of convincing the affected person to enter treatment for the condition).
26. Services for or related to therapeutic massage, except as specified in the Benefit Chart.
27. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts.
28. Dental implants and associated services and/or charges, except as specified in the Benefit Chart.
29. Services for or related to the replacement of a damaged dental bridge from an accident-related injury.
30. Services for or related to oral surgery and anesthesia for the removal of impacted teeth, except as specified in the Benefit Chart.
31. Services for or related to removal of a tooth root without removal of the whole tooth and root canal therapy.
32. Services to treat bruxism, including dental splints.
33. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.
34. Room and board expenses in a residential hospice facility.
35. Admission for diagnostic tests that can be performed on an outpatient basis.
36. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.
37. Personal comfort items, such as telephone, television, etc.
38. Communication services provided on an outpatient basis or in the home.
39. Services and prescription drugs for or related to gender selection.
40. Services and prescription drugs for or related to gender dysphoria, sex hormones related to surgery, related preparation and follow-up treatment, care counseling, unless medically necessary as determined by the Claims Administrator prior to receipt of services.
41. Services for or related to reversal of sterilization.
42. Services for or related to adoption fees and childbirth classes.
43. Services for or related to elective cesarean (C-) section for the purpose of convenience.
44. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services.

45. Donor ova or sperm.
46. Services for or related to preservation, storage and thawing of human tissue including but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Charts.
47. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Charts.
48. Services and supplies that are primarily and customarily used for a non-medical 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.
49. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.
50. Blood pressure monitoring devices.
51. Foot orthoses, except as specified in the Benefit Charts.
52. Scalp/cranial hair prostheses (wigs) for any diagnosis other than alopecia areata and except when hair loss is due to chemotherapy.
53. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
54. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Charts.
55. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
56. Services primarily educational in nature, except as specified in the Benefit Charts.
57. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.
58. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.
59. Services 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 therapy for the member's condition.
61. Maintenance services.
62. Custodial care.
63. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs.

64. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.
65. Services for or related to the repair of scars and blemishes on skin surfaces.
66. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
67. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Charts.
68. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.
69. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment: services for or related to homeopathy; or chelation therapy that the Claims Administrator determines is not medically necessary.
70. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
71. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.
72. Autopsies.
73. Charges for failure to keep scheduled visits.
74. Charges for giving injections that can be self-administered.
75. Internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit, except as specified in the Benefit Chart.
76. Provider initiated e-mail communications.
77. Services for or related to transcranial magnetic stimulation therapy.
78. Services for or related to smoking cessation program fees and/or supplies, except as specified in the Special Features section.
79. Charges for over-the-counter drugs, except as specified in the Benefit Chart.
80. Vitamin or dietary supplements, except as specified in the Benefit Chart.
81. Investigative or non-FDA approved drugs.
82. 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.
83. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
84. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.
85. Services for or related to fetal tissue transplantation.

ELIGIBILITY

Eligible Employees

You are eligible for medical coverage if Medtronic classifies you as a regular employee of Medtronic, a participating division or subsidiary. A regular employee is defined as a person on the payroll and regularly employed by Medtronic, union and non-union. All employees working a minimum of 20 hours per week are eligible.

Individuals Medtronic designates as temporary employees (including employees on a temporary agency payroll), leased employees, casual workers, interns, contract workers, independent contractors or similar classifications performing services for Medtronic, are not considered regular employees whether or not they are paid W-2 wages by Medtronic.

Retirees must contact the Plan Administrator for eligibility information.

Eligible Dependents

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

Spouse

1. Spouse, meaning:
 - a. Legally married spouse;
 - b. The employee's partner through a same gender civil union in a jurisdiction that recognizes civil unions.

Domestic Partner

Your domestic partner may remain on the Plan, if your domestic partner was covered by the Plan on or before December 31, 2015, and the partners remain continuously covered thereafter.

Domestic Partner Dependent Children

Domestic partner children may remain on the Plan, if the children were covered by the Plan on or before December 31, 2015, and the children remain continuously covered thereafter. Domestic partners and their eligible dependent children who satisfy these requirements, and remain continuously covered by the Plan may be eligible for Continuation coverage under the Plan upon the occurrence of a qualifying event (see Continuation of Group Coverage section).

Dependent Children

1. Children of a legal same gender marriage or a legal same gender civil union to age 26.
2. Natural-born dependent children to age 26.
3. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
4. Stepchildren to age 26.
5. Dependent children to age 26 for whom you or your spouse have been appointed legal guardian by a court of competent jurisdiction.

6. Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

Disabled Dependents

1. Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:
 - a. primarily dependent upon you;
 - b. are incapable of self-sustaining employment because of physical disability, 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 age 19. 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 age 19.

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.

NOTE: When you return from a leave of absence that has a benefit effect (i.e. salary continuation, personal leave, sabbatical), regular coverage will be effective the first of the month following the return from leave, provided you re-enroll.

Adding New Employees

1. If the Plan Administrator receives your application within 31 days after you become eligible, coverage for you and your eligible dependents starts on the date of hire. If you are covered by a collective bargaining agreement, you become eligible on the 61st day after you first satisfy the plan's eligibility requirements (i.e. on the 61st day after your date of hire).
2. If the Plan Administrator receives your application more than 31 days after you become eligible, you and your eligible dependents may enroll for coverage at the next open 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 31 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 31 days after the date of marriage, your spouse and/or stepchildren may enroll for coverage at the next open 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 31 days of the date of birth, coverage for your newborn child starts on the date of birth.

If the Plan Administrator receives the application within 31 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 31 days after the date of birth, your newborn child may enroll for coverage at the next open enrollment unless your newborn child meets the requirements of the special enrollment period.

If the Plan Administrator receives the application more than 31 days after the date of placement, your adopted child may enroll for coverage at the next open 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 31 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 31 days after the date of eligibility, your disabled dependent may enroll for coverage at the next open enrollment unless your disabled dependent meets the requirements of the special enrollment period.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the Plan under certain circumstances **after they were first eligible for coverage**. In order to enroll, the eligible employee or dependent **must notify the Plan Administrator within 30 days** of the triggering event. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order, in order to avoid claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements.

Special Enrollment Triggering Events

Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission):

- loss of eligibility for employer sponsored coverage;
- plan no longer offers benefits;
- termination of employer contributions
- termination of employment or reduction in hours;
- legal separation or divorce;
- loss of dependent child status;
- death of employee;
- move outside HMO or ACO service area;
- exceeding the plan's lifetime maximum;
- employer bankruptcy;
- COBRA exhaustion; or
- employee becomes entitled to Medicare.

Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.

Additional Special Enrollment Triggering Events

Gaining or becoming a dependent due to marriage.

Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.

An individual loses eligibility for Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP).

Child support order or other Court order to provide coverage.

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 service for duty lasting more than 31 days.
 - d. you request that coverage be terminated.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month during which the employee and spouse divorce.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
 - a. a covered stepchild is no longer eligible because the employee and spouse divorce.
 - b. a covered dependent is no longer eligible because the employee and the domestic partner terminate their domestic partnership.
 - c. a covered dependent is no longer eligible because the employee and the same gender spouse or civil union spouse terminate their marriage or civil union.
 - d. the dependent child reaches the dependent-child age limit.
 - e. the disabled dependent is no longer eligible.
 - f. the dependent legal ward is no longer eligible.
5. The last day of the month during which the employee and domestic partner terminate their relationship.

Retroactive Termination

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

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 of Group Coverage

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

Qualifying Events

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

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

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

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

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

- The death of the **employee**.
- The termination of the **employee's** employment (as described above) or reduction in the **employee's** hours of employment.
- Parents' divorce or legal separation.
- The **employee** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under the Plan.

Your Notice Obligations

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

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

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

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

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

Employer's and Plan Administrator's Notice Obligations

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

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

Election Procedures

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

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

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

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

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

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

Maximum Coverage Periods

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

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

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

Continuation Premiums

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

Extension of Maximum Coverage Periods

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

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

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

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

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

- **Multiple Qualifying Events:** This extension is applicable when the initial qualifying event is the **employee's** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the **employee**, divorce, legal separation, the **employee** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the **employee's** dependents that are qualified beneficiaries.

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

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

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

Example: **Employee** becomes enrolled in Medicare on January 1. **Employee's** termination of employment is May 15. The **employee** is entitled to 18 months of continuation from the date coverage is lost. The **employee's** dependents are entitled to 36 months of continuation from the date the **employee** is enrolled in Medicare.)

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

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

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- If during a 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered **employees** or their dependents whether or not they are on continuation coverage.
- Voluntarily dropping your continuation coverage.

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

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

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

Open Enrollment Rights and Special Enrollment Rights

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

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

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

Special Second Election Period

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Questions

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

Overview

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

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

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; and
 - 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);
- b. any benefits that, by law, are excess to any private or other nongovernmental program; or
- c. hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

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

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

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

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

Notes:

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

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

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

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

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

Order of Benefits Rules

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

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

- d. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, This Plan determines benefits in this order:
 - 1) first, the plan of the parent with physical custody of the child;
 - 2) then, the plan that covers the spouse of the parent with physical custody of the child;
 - 3) finally, the plan that covers the parent not having physical custody of the child; or

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

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

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

Effect on Benefits of This Plan

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.

Reduction in This Plan's benefits

1. The medical benefits that would be payable under This Plan, without applying coordination of benefits, are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under This Plan. This applies whether or not a claim is made under a plan.
2. When a plan provides medical benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable. When medical benefits of This Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

REIMBURSEMENT AND SUBROGATION

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

The Plan's Right of Subrogation

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

Obligation to Reimburse the Plan

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

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

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

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

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

Duty to Cooperate

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

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

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

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

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

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

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

Attorneys' Fees and Other Expenses You Incur

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

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

What May Happen to Your Future Benefits

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

Interpretation

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

GENERAL PROVISIONS

Plan Administration

Plan Administrator

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

Powers and Duties of the Plan Administrator

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

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

Actions of the Plan Administrator

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

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

Nondiscrimination

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

Statute of Limitations/Lawsuits

No claimant may begin any legal action to recover Plan benefits or to enforce or clarify rights under the Plan under Section 502 or Section 510 of ERISA or under any other provision of law, whether or not statutory, until the claims procedures have been exhausted in their entirety. Legal action must be commenced in the proper forum before the earlier of 30 months after the claimant knew or reasonably should have known of the principal facts on which the claim is based, or 12 months after the claimant has exhausted the claims procedure under the Plan.

Knowledge of all facts that you or your dependents knew or reasonably should have known will be imputed to every claimant who is or claims to be entitled to benefits or rights by reference to you or your dependents for the purpose of applying the time periods. In any legal action brought relating to the Plan all explicit and implicit determinations by the claims administrator, Medtronic and any other fiduciary (including determinations as to whether the claim, or a request for a review of a denied claim, was timely filed) will be given the maximum deference permitted by law.

Any review of a final decision or action of the persons reviewing a claim will be based only on the evidence presented to or considered by those persons at the time they made the decision that is the subject of review.

Termination or Changes to the Plan

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

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

Funding

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

Controlling Law

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

Privacy of Protected Health Information

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

Restrictions on the Use and Disclosure of Protected Health Information

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

Separation Between the Employer and the Plan

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

- Corporate Benefits Staff
- MEAP Staff
- HROC Staff

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

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

Employee Retirement Income Security Act (ERISA) Statement of Rights

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

Receive Information About Your Plan and Benefits

- 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.
- 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.
- 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

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.

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, 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; **however, you may not assign, convey, or in any way transfer your right to bring a lawsuit to anyone else.** 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:	Medtronic PPO Medical Plan Medtronic CHP WITH HSA Medical Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
ERISA Plan Year:	January 1 st through December 31 st
Plan Number:	The medical plans are component plans of the Medtronic Group Insurance Plan which is plan number 540.
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution toward the cost of coverage under the Plan will be determined by the Employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.
Type of Plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the Plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor/Plan Administrator:	Medtronic, Inc. 710 Medtronic Parkway NE, LC245 Minneapolis, MN 55432-5603 (763) 514-4000
Plan Sponsor's Employer Identification Number:	41-0793183
Named Fiduciary for Claims Purposes:	Blue Cross
Named Fiduciary for all other Purposes:	Medtronic 710 Medtronic Parkway NE Minneapolis, MN 55432-5603 (763) 514-4000
Agent for Services of Legal Process:	Vice President, Chief Litigation Counsel Medtronic 710 Medtronic Parkway NE Minneapolis, MN 55432-5603 (763) 514-4000 Service of legal process may also be made on the Plan Administrator.
Plan Document:	The Plan and its attachments, if any, constitute the written plan document required by ERISA §402.

GLOSSARY OF COMMON TERMS

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

Admission	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
Advanced practice nurses	Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
Allowed amount	The amount upon which payment is based for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the Benefit Chart.

The Allowed Amount for Participating Providers

For Participating Providers, the allowed amount is the negotiated amount of payment that the Participating Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating Providers for certain covered services may not be based on a specified charge for each service.

Through annual or global settlements or other special arrangements with Participating Providers the Claims Administrator may prospectively or subsequently pay a different amount to a Participating Provider without reprocessing individual claims. Such annual or global payments will not affect 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 Plan, and the percentage of the allowed amount paid by the Plan is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Plan pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

Qualifications Applicable to All Nonparticipating Providers

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this allowed amount is a usual, customary, or reasonable charge from a provider. The allowed amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the allowed amount is subject to all of the Claims Administrator's business rules as defined in the Claims Administrator Provider Policy and Procedure Manual. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The Allowed Amount for Nonparticipating Providers in Minnesota

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar service; (2) a percentage of billed charges; or (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare Advantage allowed charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator.

The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota

For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage of billed charges; (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.

Special Circumstances

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a medical emergency. Some hospital-based providers (e.g., anesthesiologists) may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the Allowed Amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, Blue Cross may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law.

If you have questions about the benefits available for services to be provided by a Nonparticipating Provider, you will need to speak with your provider and you may call the Claims Administrator Customer Service at the telephone number on the back of your member ID card for more information.

Artificial Insemination (AI)

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

Assisted Reproductive Technologies (ART)

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

Attending health care professional

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

Average semiprivate room rate	The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.
BlueCard Network Provider	Providers who have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan.
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.
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 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.
Blue Distinction Centers for Cardiac Care	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 Cardiac Care have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.
Blue Distinction Centers for Transplants	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. The Blue Distinction Centers for Transplants program examines eight (8) transplant types: heart, lung (deceased and living donor), combination heart bilateral lung, liver (deceased and living donor), simultaneous pancreas kidney (SPK), pancreas (PAK/PTA), combination liver kidney, and bone marrow/stem cell (autologous & allogeneic). Additional value-added services provided within this network include global pricing, financial savings analysis and global claims administration support, as well as support services such as referral management, patient satisfaction survey reports and transplant-related continuing education programs for Blue Plans. These facilities must meet stringent quality criteria, as established by expert physician panels and national organizations. The national Blue Distinction Centers for Transplants have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.
Calendar year	The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care/case management plan	A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.
Claim	<p>A written submission from your provider (or you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is not covered, the claim will be denied, meaning no payment is allowed.</p> <p>Providers are required to use certain codes to explain the care they give you. The provider's medical records must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to contact your provider.</p>
Claims Administrator	Blue Cross and Blue Shield of Minnesota (Blue Cross)
Coinsurance	<p>The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket maximum. For covered services from 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.</p> <p>For covered services from Out-of-Network Providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible to the provider for any excess charge over the allowed amount.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.</p> <p>Coinsurance Example:</p> <p>You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:</p>

For instance, when the Claims Administrator pays 70% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 30% 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 70% of the allowed amount (\$66.50). You must pay the 30% coinsurance on the Claims Administrator's allowed amount (\$28.50), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$33.50.

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 (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added. The compound must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.
Comprehensive pain management program	A multidisciplinary program including, at a minimum, the following components: <ol style="list-style-type: none"> 1. a comprehensive physical and psychological evaluation; 2. physical/occupation therapies; 3. a multidisciplinary treatment plan; and 4. a method to report clinical outcomes.
Convenience care	See Retail health clinic.
Copay	<p>The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays.</p> <p>A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.</p>
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 and supplies that are primarily intended to help someone meet personal needs or to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.
Cycle	One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day treatment	Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.
Deductible	<p>The amount you must pay toward the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each person and family are shown on the Benefit Charts.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.</p>
Dependent	Your spouse, child to the dependent child age limit specified in the Eligibility section, child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the Eligibility section, disabled dependent or dependent child as defined in the Eligibility section, or any other person whom state or federal law requires be treated as a dependent under this Plan.
Drug therapy supply	A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.
Durable medical equipment	<p>Medical equipment prescribed by a physician that meets each of the following requirements:</p> <ol style="list-style-type: none"> 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 applicable state 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	A patient initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider 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, home health agency, or freestanding birthing center when services are billed on a facility claim.

Family therapy	Behavioral health therapy intended to treat an individual within the context of family relationships. The focus of the treatment is to identify problems or conflicts and to set specific goals for resolving them.
Foot orthoses	Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity; protect against injury; or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.
Freestanding ambulatory surgical center	A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.
Group home	A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.
Group therapy	Behavioral health therapy conducted with multiple patients.
Habilitative services	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.
Halfway house	Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.
Health care professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dietitians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
Home health agency	A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.
Hospice care	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.

Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Host Blue	A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that requires such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.
Illness	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
In-Network Provider	A provider that has entered into a specific network contract with the Claims Administrator for this plan or with the local Blue Cross and/or Blue Shield Plan. Refer to the Benefit Chart and Coverage Information sections for network details.
Infertility testing	Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.
Intensive Outpatient Programs (IOP)	A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.
Intrauterine Insemination (IUI)	A specific method of artificial insemination in which semen is introduced directly into the uterus.
Investigative	<p>At the time a determination is made regarding coverage in a particular case, a drug, device, diagnostic or screening procedure, or medical treatment or procedure will be determined to be investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator will base its determination upon an examination of the following reliable evidence, none of which is determinative in and of itself:</p> <ol style="list-style-type: none"> 1. whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II, or III trials; 2. whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and, 3. whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers. <p>All determinations of reliable evidence shall be made by the Claims Administrator.</p>

Notwithstanding the above, a drug, device, diagnostic or screening procedure, or medical treatment or procedure will not be considered to be investigative with respect to a specific diagnosis or condition when it is the subject of ongoing Phase III clinical trials or the Claims Administrator determines on a case-by-case basis that (a) reliable evidence demonstrates that the drug, device, medical treatment or procedure for the specific diagnosis or condition is safe and efficacious, and (b) In-Network Providers practicing in the applicable specialty or subspecialty have concluded that the drug, device, medical treatment or procedure is not investigative, and (c) if applicable, the FDA has indicated that the approval of the drug or device for the proposed use is pending and likely to occur.

Notwithstanding the above, a drug, including cancer drugs, being used for an indication or at a dosage that is an accepted off-label use will not be considered to be investigative. The plan will determine if a use is an accepted off-label use based on published reports in peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations and entries in the following drug compendia: The American Hospital Formulary Service Drug Information and the United States Pharmacopoeia Dispensing Information.

Lifetime maximum	The cumulative maximum payable for certain 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 Charts for specific dollar maximums on certain services.
Mail order pharmacy	A pharmacy that dispenses prescription drugs through the U.S. Mail.
Maintenance services	Services that are neither habilitative nor rehabilitative 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 therapy for the member's condition.
Maintenance medication	A prescription drug that is ordered on a regular, scheduled, ongoing basis.
Marital/couples counseling	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.

Medicare allowed charge

The charge that Medicare would authorize as the cost of a service or supply from a provider that participates in Medicare. The Medicare allowed charge is adjusted by location in the United States according to Geographic Practice Cost Indices (GPCIs) calculated by Medicare. The Medicare allowed charge for covered inpatient care is based upon the Acute Hospital Inpatient Prospective Payment System (PPS). The Medicare allowed charge does not include additional amounts, such as Disproportionate Share Hospital, Direct Graduate Medical Education, outlier amounts or other charges that are not included in the Prospective Payment System amount. Payment for physician services is based solely upon the Medicare Physician Fee Schedule.

The determination of the allowed amount is subject to all Medicare payment rules. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or other reductions consistent with Medicare payment procedures resulting from the procedures performed and billed on the claim.

The Medicare allowable charge that is current as of the time the services are provided will be the amount that is used in determining the allowed amount.

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.

Mental illness

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

Mobile crisis services	Face-to-face short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.
Neuro-psychological examinations	Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.
Nonparticipating Provider	A provider that has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
Opioid treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Network Provider	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	<p>The most each person must pay each applicable plan or calendar year toward the allowed amount for covered services.</p> <p>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.</p>
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 pharmaceutical provider that participates in a network for the dispensing of prescription drugs.
Participating Provider	A provider who has entered into either a specific network contract or a general broader network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.

Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Place of service	<p>Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers.</p> <p>Providers use different types of claim forms to bill for services based on the “place of service.” Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician’s office may be different than diagnostic imaging delivered in an outpatient facility.</p>
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, as stated in the Introduction section, and each succeeding 12-month period thereafter.
Preferred drug list	A list of prescription drugs and drug therapy supplies used by patients in an ambulatory care setting. Over-the-counter drugs, injectable medications, and drug therapy supplies are not included in your specified preferred drug list unless they are specifically listed.
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 that health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.
Qualifying Creditable coverage	Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, Medicare, MinnesotaCare, Medical Assistance (Medicaid), General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan, the 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 Minnesota Commissioners of Commerce or Health.
Rehabilitative Services	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Reproduction treatment	Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.
Residential behavioral health treatment facility	A facility licensed under state law in the state in which it is located that provides inpatient treatment by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
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 rendered other than in a skilled nursing facility that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.
Skilled nursing care – extended hours	<p>Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home.</p> <p>Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.</p>

Skilled nursing care – intermittent hours	Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.
Skilled nursing facility	A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.
Skills training	Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment and the requirements of everyday independent living.
Smoking cessation drugs	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
Specialty drugs	Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia.
Specialty Pharmacy Network	A nationwide pharmaceutical specialty provider that participates in a network for the dispensing of certain oral medications and injectable drugs.
Step therapy	Step therapy includes, but is not limited to medications in specific categories or drug classes. If your physician prescribes one of the following medications: ACE/ARB/Renin inhibitors; Anticonvulsants; Actos/Avandia; Atopic dermatitis; Atypical antipsychotics; Depression; COX-2 inhibitors; DPP4-Byetta; GLP1 Byetta; Growth hormones; Insomnia; Leukotriene modifiers; Multiple sclerosis; Proton Pump Inhibitors (PPI); Rheumatoid arthritis/Psoriasis; Statins; Vimovo; and Zetia, there must be documented evidence that you have tried another eligible medication in the same or different drug class before the step therapy medication will be paid under the drug benefit.
Substance abuse and/or addictions	Alcohol, drug dependence or other addictions as defined in the most current editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).
Supervised employees	Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50 percent of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supply	<p>Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.</p> <p>Supplies do not include such things as:</p> <ol style="list-style-type: none"> 1. alcohol swabs; 2. cotton balls; 3. incontinence liners/pads; 4. Q-tips; 5. adhesives; or 6. informational materials.
Surrogate pregnancy	An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.
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.
Tobacco cessation drugs and products	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, and monitoring and taking medication.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.
Waiting period	The period of time that must pass before you or your dependents are eligible for coverage under the health plan.