PREFERRED PROVIDER ORGANIZATION (PPO) HEALTH CARE PLAN

For Employees of:

White Earth Band of Chippewa Indians/National Tribal Claim Center

(herein called the Plan Administrator or the Employer)

ANNUAL NOTIFICATIONS

Women's Health and Cancer Rights Act

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

1. reconstruction of the breast on which the mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

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

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Claims Administrator and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. **The Claims Administrator has determined that the prescription drug coverage offered through your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. You may keep your current coverage with the Claims Administrator and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents might not be able to get this coverage back.

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

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

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

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

Contact Customer Service at the telephone number provided in the Customer Service section.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through the Claims Administrator changes. You may request a copy of this notice anytime.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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INTRODUCTION

This Summary Plan Description (SPD) contains a summary of the White Earth Band of Chippewa Indians/National Tribal Claim Center Preferred Provider Organization (PPO) Health Care Plan for benefits effective October 1, 2016.

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

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

This Plan, financed and administered by White Earth Band of Chippewa Indians/National Tribal Claim Center, is a self-insured medical plan. CCS*tpa* is the Claims Administrator and provides administrative services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity.

This Plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use In-Network Providers. In-Network Providers have a contract with the Claims Administrator specific to this Plan to provide you quality health services at favorable prices. These providers are also referred to as Participating Providers.

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

If you are receiving services outside the service area, you have access to In-Network Providers through a special arrangement between CCS*tpa* and Private HealthCare Systems (PHCS). Please contact PHCS at 1-888-940-7427 to locate a provider. For all other questions, please contact Customer Service.

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

CUSTOMER SERVICE

Questions?	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for 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. Monday through Friday: 8:00 am – 4:30 pm United States Central Time Hours are subject to change without prior notice.
Customer Service Telephone Number	Claims Administrator: (218) 983-4680 or toll free 1-855-917-7480
CCS*tpa* Website	www.ccstpa.com
Claims Administrator's Mailing Address	Claims review requests, and written inquiries may be mailed to the address below: CCStpa P.O. Box 64668 St. Paul, MN 55164-0668 Prior authorization requests should be mailed to the following address: CCStpa Utilization Management Department P.O. Box 64265 St. Paul, MN 55164
Pharmacy Telephone Number	Toll free 1-800-509-0545 This number is used to locate a participating pharmacy.
PHCS Telephone Number	Toll free 1-888-940-7427 This number is used to locate PHCS Providers.
Prenatal Support Telephone Number	Toll free 1-866-938-9743 Call this number to enroll in the Prenatal Support Program.
Stop-Smoking Support	Toll free 1-888-662-QUIT (7848) Call to enroll in Stop-Smoking Support.

SPECIAL FEATURES

Prenatal Support

Prenatal Support provides education and support to pregnant women so they can achieve the healthiest pregnancies possible. Pregnant women who are at high risk for complications are connected with a dedicated registered nurse to support them during their pregnancy. All pregnant women have access to online tools and resources. To request further information or to enroll, call 1-866-938-9743.

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-QUIT (7848). A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns.

Case Management

If you or an eligible family member experience a major health event or illness - you may be eligible to take advantage of the Case Management program. This program is voluntary and confidential. A Health Coach (registered nurse or behavioral health specialist) can help you coordinate care and navigate the healthcare system, identify resources to assist you in achieving your personal health goals and provide you with information that is specific to your needs.

Online Health Risk Assessment and Online Health Coaching Courses

The Online Health Risk Assessment and Online Health Coaching Courses are available to members 18 years of age or older at ccstpa.com, the Claims Administrator's website. Taking the Online Health Risk Assessment is your first step to a healthier lifestyle. Answer questions about your health history, nutrition, physical activity, and more. You will instantly get a report just for you. It takes just 20 minutes and is completely confidential. Then take advantage of the Online Health Coaching Courses focused on fitness, nutrition, weight loss, reducing stress, and more. Each program includes an action plan and tips for success to keep you on track.

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 ccstpa.com. Watch for credits 30-60 days after each month the visit requirement is met.

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.

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.

In-Network Providers

When you choose these providers, you get the most benefits for the least expense and paperwork. In-Network Providers have a contract with the Claims Administrator specific to this Plan. In-Network Providers send your claims to the Claims Administrator and the Claims Administrator sends payment to the provider for covered services you receive. In-Network Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements for you (refer to the Notification Requirements section). The provider directory lists In-Network Providers and may change as providers initiate or terminate their agreements. For a complete list of In-Network Providers refer to the Claims Administrator's website. For benefit information on these providers, refer to the Benefit Chart.

Out-of-Network Providers

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

Your Benefits

This 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.

Continuity of Care

Continuity of Care for New Members

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

Continuation for up to 120 days if you:

1. have an acute condition;

2. have a life-threatening mental or physical illness;

3. have a physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;

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

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

6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-Network Providers

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

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Claims Administrator's prior authorization requirements and 2) provide the Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Continuity of Care for Current Members

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

Continuation for up to 120 days if you:

1. have an acute condition;

2. have a life-threatening mental or physical illness;

3. have a physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;

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

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

6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-Network Providers

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

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Claims Administrator's prior authorization requirements and 2) provide the Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

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; and

4. charges for services that are not covered.

Out-of-Network Providers

When you use Nonparticipating Providers for covered services, payment is still based on the allowed amount. However, because a Nonparticipating Provider has not entered into a network contract with the Claims Administrator, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full. You are responsible for payment of any billed charges that exceed the allowed amount. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. 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 or Nonparticipating Providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Provider Payment Methods

Withhold and Bonus Payment Disclosure

Several methods are used to pay the Claims Administrator's health care providers. Some providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 – 20 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 person per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

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

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

Recommendations by Health Care Providers

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

Services that are Investigative or not Medically Necessary

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

Fraudulent Practices

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

Time Periods

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

Medical Policy Committee 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.

In-Network Providers are required to obtain prior authorization for you.

You are required to obtain prior authorization when you use a Nonparticipating Provider. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you. **If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.** The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

The prior authorization list is subject to change due to changes in the Claims Administrator's medical policy. The 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 or by calling Customer Service.

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

Preadmission Notification

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

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

If you are going to receive nonemergency care from a Nonparticipating Provider, you are responsible for providing preadmission notification to the Claims Administrator. Some Nonparticipating Providers may provide preadmission notification for you. Verify with your providers if this is a service they will provide for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

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

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

Preadmission Certification

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

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

Preadmission certification is required for the following admissions/facilities:

1. Acute rehabilitation (ACR) admissions;

2. Long-term acute care (LTAC) admissions; and

3. Skilled nursing facilities.

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

Emergency Admission Notification

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

If you have an emergency admission to a Nonparticipating Provider, you are required to provide emergency admission notification to the Claims Administrator as soon as reasonably possible. Some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you. **If it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

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

CLAIMS PROCEDURES

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

Types of Claims

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

Pre-service Claim

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

Urgent Care Claim

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

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

Concurrent Care Claim

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

Post-service Claim

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

Change in Claim Type

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

Filing Claims

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

Urgent Care Claims

An Urgent Care Claim may be submitted to the Claims Administrator by telephone at (218) 983-4680 or toll free 1-855-917-7480.

Pre-service Claims

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

Post-service Claims

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

Incorrectly-Filed Claims

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

Timeframes for Deciding Claims

Urgent Care Claims

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

Pre-service Claims

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

Concurrent Care Extension Request

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

Concurrent Care Reduction or Early Termination

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

Post-Service Claims

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

Extensions of Time

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

Incomplete Claims

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

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

Notification of Initial Benefit Decision

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

Appeals of Adverse Benefit Determinations

Appeal Procedures

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 to the Claims Administrator by telephone at (218) 983-4680 or toll free 1-855-917-7480. 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 the 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 In-Network or Out-of-Network Participating Providers, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and 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.

BENEFIT CHART

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

Benefit Features, Limitations, and Maximums

Benefit Features	Your Liability
Deductible	
(Does not include copays)	
• All providers combined	$3,000 per person per calendar year $6,000 per family per calendar year

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
Note: Price differences between brand name and generic drugs may be your responsibility in certain instances. This amount is your responsibility and is not credited towards any out-of-pocket maximum.	
• In-Network Providers	$4,500 per person per calendar year $6,500 per family per calendar year
• Out-of-Network Providers	$9,000 per person per calendar year $18,000 per family per calendar year

The following items are applied toward the out-of-pocket maximum:
1. coinsurance;
2. deductibles; and
3. prescription drug copays.

Lifetime Maximum	
• Total benefits paid to all providers combined	Unlimited

Benefit Descriptions

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

Ambulance

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• 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 condition • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	80% after you pay the deductible.	80% after you pay the deductible.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- 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

1. 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

Behavioral Health Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ individual/group/family therapy (office/in-home mental health services) ▪ neuro-psychological examinations • Professional health care charges for services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy • Inpatient health care professional charges • Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based Intensive Outpatient Programs (IOP) ▪ all eligible inpatient services ▪ emergency holds	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Treatment of emotionally disabled children in a licensed residential behavioral health treatment facility	80% after you pay the deductible.	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds” as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- 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 diagnosable mental health conditions, including autism and eating disorders.
- 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 marital /couples counseling
- services for or related to marital /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

Behavioral Health Substance Abuse Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ family therapy ▪ opioid treatment • Outpatient hospital/outpatient behavioral health treatment facility charges for services including Intensive Outpatient Programs (IOP) and related aftercare services • Inpatient health care professional charges • Inpatient hospital/residential behavioral health treatment facility charges	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds”, as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- 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, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
- please refer to the General Exclusions section

Chiropractic Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Office visits from a Doctor of Chiropractic • Manipulations • Therapies • Other chiropractic services	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- 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 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
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- The Plan covers anesthesia and inpatient and outpatient hospital charges 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 medical services, refer to Hospital Inpatient, Hospital Outpatient, Physician Services, etc.
- Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.

- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound and healthy natural tooth.

NOT COVERED:

- 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
• 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:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network 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

Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• 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: ▪ intermittent skilled nursing care in your home by a: - 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 masters 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 ▪ medical supplies provided by the home health agency ▪ home health care following early maternity discharge ▪ palliative care ▪ prescription drugs	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except for certain individuals who are also covered under Medical Assistance (MA) – 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
• 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: ▪ 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.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.

NOT COVERED:

- home infusion services or supplies not specifically listed as covered services
- nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- services that do not involve direct patient contact, such as delivery charges and recordkeeping
- 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
• Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice including: ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care	80% after you pay the deductible.	70% after you pay the deductible, 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.
- Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

- 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
• 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 • Take home-prescription drugs • Lab and diagnostic imaging • Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Bariatric surgery	80% after you pay the deductible.	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- 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 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.

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, except for certain individuals who are also covered under Medical Assistance (MA) – 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
• Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational, and speech therapy • Lab and diagnostic imaging • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Take-home prescription drugs • Facility urgent care services • All other outpatient hospital care	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Bariatric surgery	80% after you pay the deductible.	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- The Plan covers anesthesia 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 outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- please refer to the General Exclusions section

Infertility Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Artificial insemination (AI) and intrauterine insemination (IUI) procedures • Injectable drugs administered by a health care professional • Related services and supplies	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Self-administered injectable and oral prescription drugs	For the level of coverage, refer to Prescription Drugs and Insulin	For the level of coverage, refer to Prescription Drugs and Insulin

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Benefits for artificial insemination (AI) or intrauterine insemination (IUI) procedures are limited to a maximum of $2,000 per person per calendar year.
- 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 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 and prescription drugs for or related to assisted reproductive technology (ART) procedures, except that the Plan does cover services and prescription drugs for artificial insemination (AI) and intrauterine insemination (IUI) procedures
- services and prescription drugs for or related to gender selection services
- please refer to the General Exclusions section

Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Inpatient and outpatient hospital/facility charges for delivery	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Inpatient and outpatient hospital/facility charges for postpartum care	100%	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- For prenatal care benefits, refer to Preventive Care.
- Refer to the Eligibility section to determine when baby's coverage will begin.
- Group health plans such as this Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may under federal law, require that a provider obtain authorization from the Claims Administrator for prescribing a length of stay greater than 48 hours (or 96 hours).
- 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
- childbirth classes
- services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- 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
• 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, related equipment and devices, and supplies • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years. • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp/cranial hair prostheses (wigs) provided hair loss is due to alopecia areata. Maximum of one (1) per person per calendar year. • Custom foot orthoses only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet.	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- For coverage of insulin, refer to Prescription Drugs and Insulin.
- 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
- services for or related to hearing aids or devices, except as specified in the Benefit Chart
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- devices for maintenance services
- please refer to the General Exclusions section

Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech or language pathologist • Therapies	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
• Office visits from a physician	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- For lab and diagnostic imaging services billed by a health care professional, refer to Physician Services.
- For hospital/facility charges, refer to Hospital Inpatient and Hospital Outpatient.
- Office visits 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
• Retail health clinic office visit (for services other than the office visit charge, see below) • E-Visits • Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon	80% after you pay the deductible.	**NO COVERAGE.**
• Office visits ▪ illness ▪ urgent care • Lab and diagnostic imaging • Allergy testing, serum, and injections • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization (see NOTES) • Assistant surgeon • Kidney and cornea transplants • Injectable drugs administered by a health care professional • Palliative care	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- The Plan covers certain physician services for preventive care. Refer to Preventive Care.
- 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.
- 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.
- An 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.
- A retail health clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers hearing aid exams/fittings/adjustments for children age 18 and younger.

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 and Insulin

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescription drugs ▪ insulin ▪ prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips; needles and syringes; and lancets ▪ prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated Specialty drugs (see 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	80% after you pay the deductible when you present your ID card or otherwise provide notice of coverage at the time of purchase.	80% after you pay the 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.
• 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 Immunization Practices (ACIP) of the Centers of Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply	100%	100%, 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.

• Benefits are provided for designated 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 more information regarding contraceptive or preventive prescription drug coverage, visit the Claims Administrator's website.		
• Designated Specialty drugs purchased through a participating specialty pharmacy network supplier (see NOTES)	80% after you pay the deductible.	**NO COVERAGE.**
• 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.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- For information regarding contraceptive coverage, please visit the Claims Administrator's website or contact Customer Service.
- The RxF preferred drug list applies to your Plan. For a list of drugs on your specified preferred drug list, visit the Claims Administrator's website or contact Customer Service.
- 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 member liability cost-sharing 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 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through the Claims Administrator's website.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network out-of-pocket maximum.
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.

- 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 on the Claims Administrator's website 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 the Claims Administrator's website or contact Customer Service. Specialty drugs are not available through 90dayRx.
- You have the option to obtain up to a 93-day authorized supply of ongoing, long-term prescription medications through a participating 90dayRx retail pharmacy or mail service pharmacy for your ongoing, long-term refills. You may visit the Claims Administrator's website or contact Customer Service to locate a retail pharmacy participating in the 90dayRx Network or mail service pharmacy.
- Prescription drugs and diabetic supplies are generally covered in a 31-day supply from a retail pharmacy or up to a 93-day supply from 90dayRx. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- 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.
- Self-administered injectable and oral prescription drugs for infertility must be obtained through a Specialty pharmacy network supplier and are subject to a maximum benefit of $2,000 per person per calendar year.
- If your physician has indicated that a brand name drug be Dispense as Written (DAW), you will not be charged the difference between the brand name and the generic drug. This provision does not apply to preventive contraception coverage 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).
- The Plan covers prescription tobacco cessation drugs and products and over-the-counter (OTC) tobacco cessation drugs and products with a physician's prescription subject to your applicable member cost-sharing. Participants in Stop-Smoking Support may use documented enrollment in place of a physician's prescription for OTC tobacco cessation drugs and products. Some quantity limitation may apply.
- The Plan will cover off label drugs used for cancer treatment as specified by law.
- When identical chemical entities are 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, except as required by law
- vitamin or dietary supplements, except as specified in the Benefit Chart
- weight loss medications
- Specialty drugs not purchased through a Specialty pharmacy network supplier

- prescription drugs for or related to assisted reproductive technology (ART), except that the Plan does cover prescriptions for artificial insemination (AI) and intrauterine insemination (IUI) procedures
- nonprescription supplies such as alcohol, cotton balls and alcohol swabs
- selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
- please refer to the General Exclusions section

Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• 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: ▪ adults ▪ infants and children	100%	100%, plus you pay any charges billed to you that exceed the allowed amount.
▪ prenatal care	100%	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Preventive care services comply with state and federal statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the purchase of a manual breast pump.
- 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.
- For newborn inpatient professional services, refer to Physician Services.
- Certain vaccines are also covered under the Retail Pharmacy Vaccine Program. Refer to Prescription Drugs and Insulin.
- 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
• 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:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Under the Federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.

NOT COVERED:

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

Skilled Nursing Facility

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Take-home prescription drugs • Physical, occupational, and speech therapy	80% after you pay the deductible.	70% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Coverage is limited to a maximum benefit of 120 days per person per calendar year.
- You must be admitted within 30 days after hospital admission of at least three (3) consecutive days for the same illness.

NOT COVERED:

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

Transplant Coverage

The Plan Covers:	Participating Transplant Providers	Nonparticipating Transplant Providers
The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart - lung • Kidney – pancreas transplant performed simultaneously (SPK) • Liver – deceased donor and living donor • Lung – single or double • Pancreas transplant – deceased donor and living donor segmental ▪ Pancreas Transplant Alone (PTA) ▪ Simultaneous Pancreas – Kidney transplant (SPK) ▪ Pancreas transplant After Kidney transplant (PAK) • Small-bowel and small-bowel/liver	100% of the Transplant Payment Allowance for the transplant admission. 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.	**NO COVERAGE FOR MINNESOTA RESIDENTS.** Non-Minnesota residents refer to the NOTES section.

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.**

NOT COVERED:

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

DEFINITIONS:

- **Participating Transplant Center** means a hospital or other institution that has a contract with CCS*tpa* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures.
- **Transplant Payment Allowance** means the amount the Plan pays for covered services to a 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.

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatment, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.
3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.
4. Services that are provided without charge, including services of the clergy.
5. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.
6. 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 for or related to therapeutic acupuncture, except for the treatment of chronic pain (defined as a duration of at least six (6) months) or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
8. 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.
9. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
10. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
11. 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.
12. 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.
13. Services for dependents if you have employee-only coverage.
14. Services that are prohibited by law or regulation.
15. Services which are not within the scope of licensure or certification of a provider.
16. Charges for furnishing medical records or reports and associated delivery charges.
17. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the Benefit Chart.
18. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.
19. Services for or related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).*
20. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.

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

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

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

24. Services for or related to marital /couples counseling.

25. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

26. Charges made by a health care professional for physician/patient telephone consultations.

27. 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).*

28. Services for or related to substance abuse interventions (defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person) with the intent of convincing the affected person to enter treatment for the condition.

29. Services for or related to therapeutic massage.

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

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

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

33. Services for or related to oral surgery and anesthesia for the removal of impacted teeth, except as specified in the Benefit Chart.

34. Services for or related to oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy.

35. Services to treat bruxism, including dental splints.

36. 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.

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

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

39. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as specified in the Benefit Chart.

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

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

42. Services and prescription drugs for or related to gender selection.

43. Services and prescription drugs for or related to reproduction treatment including assisted reproductive technology (ART) procedures, except that the Plan does cover services and prescription drugs for artificial insemination (AI) and intrauterine insemination (IUI) procedures.

44. Services and prescription drugs for or related to gender identity disorder, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling.

45. Services for or related to reversal of sterilization.

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

47. Services for or related to elective cesarean (C-) section for the purpose of convenience.

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

49. Donor ova or sperm.

50. 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.

51. 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.

52. 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.

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

54. Blood pressure monitoring devices.

55. Foot orthoses, except as specified in the Benefit Chart.

56. Scalp/cranial hair prostheses (wigs).

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

58. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.

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

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

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

62. 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.

63. 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.

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

65. 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.

66. Maintenance services.

67. Custodial care.

68. 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.

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

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

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

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

73. 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.

74. 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.

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

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

77. Autopsies.

78. Charges for failure to keep scheduled visits.

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

80. 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.

81. Provider initiated e-mail communications.

82. Services for or related to transcranial magnetic stimulation therapy.

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

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

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

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

87. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

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

89. 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.

90. Services for or related to fetal tissue transplantation.

Eligible Employees

All full time employees working a minimum of 30 hours per week are eligible.

The waiting period is 60 days.

This Plan covers only those employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Dependents

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

Spouse

Spouse, meaning:

a. Legally married spouse; or

b. Domestic Partner of the unmarried employee. An adult whom the Plan Administrator determines:

   1) is in a committed and mutually exclusive relationship, jointly responsible for the domestic partner's welfare and financial obligations; and

   2) is at least 18 years of age and unmarried; and

   3) resides with the domestic partner in the same principal residence and intends to do so permanently; and

   4) is not a blood relative of the domestic partner; and

   5) is mentally competent.

Dependent Children

1. Unmarried children of the domestic partner of the employee 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 for whom you or your spouse have been appointed legal guardian to age 26.

6. Foster children placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.

7. Unmarried grandchildren to age 26 who live with you continuously from birth and are financially dependent upon you.

8. 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

Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

a. primarily dependent upon you;

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

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

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

Effective Date of Coverage

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

Adding New Employees

1. If the Plan Administrator receives your application within 31 days after you become eligible, coverage for you and your eligible dependents starts on the first of the month following the waiting period.

2. If the Plan Administrator receives your application more than 30 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual 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 30 days after the date of marriage, your spouse and/or stepchildren must reapply for coverage at the next annual open enrollment unless your spouse and/or stepchildren meet the requirements of the special enrollment period.

Adding newborns, children placed for adoption or foster care, and court ordered dependents

The Plan Administrator requests that you submit written application to add your newborn child or newborn grandchild within 31 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Administrator requests that you submit written application to add your adopted or foster child within 31 days of the date of placement. Coverage for your adopted or foster child starts on the date of placement.

If coverage is sought pursuant to a child support order or other order to provide coverage, coverage may be effective as of the date of the court order.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Administrator receives the application. A disabled dependent will not be denied coverage.

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 31 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 31 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 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.
    e. you retire.
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, legally separate, or the domestic partner no longer meets the domestic partner requirements.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
    a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
    b. a covered dependent is no longer eligible because the employee and the domestic partner terminate their domestic partnership.
    c. the dependent child reaches the dependent-child age limit.
    d. the disabled dependent is no longer eligible.
    e. the dependent grandchild is no longer eligible.

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

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

Qualifying Events

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

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

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

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

Your Notice Obligations

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

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

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

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

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

Employer's and Plan Administrator's Notice Obligations

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

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

Election Procedures

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

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

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

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

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

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

Maximum Coverage Periods

Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of Continuation Coverage Before the End of the Maximum Coverage Period.” In other

instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

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

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

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a dependent's disability, the premiums for continuation 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. All premiums are paid directly to the employer.

Extension of Maximum Coverage Periods

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

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

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

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

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

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

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

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

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

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

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

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

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- After electing continuation, you or your dependents become covered under another group health plan that has 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 any covered ***employees*** or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

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

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

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

Open Enrollment Rights and Special Enrollment Rights

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

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

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

Special Second Election Period

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Questions

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

Overview

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

Qualifying Event/ Extension	Who May Continue	Maximum Continuation Period
• Employment ends (for reasons other than gross misconduct) • Reduction in hours of employment (layoff, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and dependents	Earlier of: 1. 18 months; or 2. Enrollment date in other group coverage.
• Divorce or legal separation	Ex-spouse/spouse and any dependent children who lose coverage	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Death of employee	Surviving spouse and dependent children	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end if the employee had lived.
• Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Dependents lose eligibility due to the employee's enrollment in Medicare	All dependents	Earliest of: 1. 36 months; or 2. Enrollment date in other group coverage; or 3. Date coverage would otherwise end.
• Retirees of the employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree Dependents	Lifetime continuation Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: • Disability, as determined by the Social Security Administration, of employee or dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the employee leaves employment; or 2. Date disability ends; or 3. Date coverage would otherwise end.

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 or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Plan determines benefits in this order:

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

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

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

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

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

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

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

Effect on Benefits of This Plan

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

2. Reduction in This Plan's benefits

   When the sum of:

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

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

      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.

***CCStpa* as Claims Administrator may provide Protected Health Information (PHI) to the Plan for the Plan's use in identifying and pursuing subrogation and/or reimbursement claims.**

Plan Administration

Plan Administrator

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

Powers and Duties of the Plan Administrator

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

1. construe and interpret the provisions of the Plan and decide all questions of eligibility.

2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Plan;

3. prepare and distribute information to you explaining the Plan;

4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Plan;

5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Plan; and

6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Plan.

Actions of the Plan Administrator

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

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

Nondiscrimination

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

Termination or Changes to the Plan

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

The Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Internal Revenue Code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the Employer. 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:

- Benefit Administrator, Benefit Assistant, Claims Supervisor, Customer Service Representative, Claims Examiner

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

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

Employee Retirement Income Security Act (ERISA) Statement of Rights

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you should disagree with the Plan's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in federal court; **however, you may not assign, convey, or in any way transfer your right to bring a lawsuit to anyone else**. If it should happen that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

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

Important Plan Information

Plan Name:	White Earth Band of Chippewa Indians Employee Benefit 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:	October 1 through September 30
Plan Number:	501
Funding Medium:	This Plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contribution toward the cost of coverage under the Plan will be determined by the Employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.
Type of Plan Administration:	Claims are administered by CCS*tpa* pursuant to a contract between the Plan and CCS*tpa*.
Plan Sponsor:	White Earth Band of Chippewa Indians/National Tribal Claims Center 35500 Eagle View Road White Earth, MN 56591-0270 (218) 983-4652
Plan Sponsor's Employer Identification Number:	41-1737979
Plan Administrator:	White Earth Band of Chippewa Indians/National Tribal Claims Center 35500 Eagle View Road White Earth, MN 56591-0270 (218) 983-4652
Named Fiduciary for Claims Purposes:	CCS*tpa*

Named Fiduciary for all other Purposes:	White Earth Band of Chippewa Indians/National Tribal Claims Center 35500 Eagle View Road White Earth, MN 56591-0270 (218) 983-4652
Agent for Services of Legal Process:	CFO White Earth Band of Chippewa Indians/National Tribal Claims Center 35500 Eagle View Road White Earth, MN 56591-0270 (218) 983-4652 Service of legal process may also be made on the Plan Administrator.
Plan Document:	The Plan and its attachments, if any, constitute the written plan document required by ERISA §402.

GLOSSARY OF COMMON TERMS

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

90dayRx

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

Admission

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

Advanced practice nurses

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

Allowed amount

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

For 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, rebates, and other methods, the Claims Administrator may subsequently adjust the amount due to a Participating Provider without reprocessing individual claims. These subsequent adjustments will not impact or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Claims Administrator or the Plan Administrator, and the percentage of the allowed amount paid by the Claims Administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Claims Administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

For Nonparticipating Providers, the allowed amount is the lesser of billed charge or a percentage of what the Plan would pay a Participating Provider for the same or similar services.

The Claims Administrator makes no representations that the allowed amount for Nonparticipating Providers 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.

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.
Business associate	An organization such as the Claims Administrator or the Claims Administrator's vendors with which the employer and/or the Claims Administrator has a formal agreement to protect the privacy of your personal health information.
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	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. 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.
Claims Administrator	CCS*tpa*
Coinsurance	The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from Participating Providers, coinsurance is calculated based on the lesser of the allowed amount or the Participating Provider's billed charge. Because payment amounts are negotiated with Participating Providers to achieve overall lower costs, the allowed amount for Participating Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for Participating Providers, the percentage of the allowed amount paid

by the Claims Administrator will be greater than the stated percentage.

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

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

Coinsurance Example:

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

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

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

Compound drug

A prescription where two (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:

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

Copay

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

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

Cosmetic services

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

Covered services

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

Custodial care

Services 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

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

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

Dependent

Your spouse, child to the dependent child age limit specified in the Eligibility section, child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the Eligibility section, unmarried grandchild who meets the eligibility requirements as defined in the Eligibility section to the age specified, disabled dependent or dependent child as defined in the Eligibility section, or any other person whom state or federal law requires be treated as a dependent 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

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

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

E-Visit

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.

Emergency hold	A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.
Enrollment date	The first day of coverage, or if there has been a waiting period, the first day of the waiting period (typically the date employment begins).
Facility	A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, 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, diagnosed with a behavioral health condition, within the context of family relationships.
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 dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home health agency

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

Hospice care

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

Hospital

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

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. In-Network Providers are also known as Participating Providers. Refer to the Benefit Chart and Coverage Information sections for network details.

Infertility testing

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

Intensive Outpatient Programs (IOP)

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

Intermediate maximum

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

Intrauterine Insemination (IUI)

A specific method of artificial insemination in which semen is introduced directly into the uterus.

Investigative

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

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not

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

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

Lifetime maximum

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

Mail service pharmacy

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

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.

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.
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 most current editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM). 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 its subsidiaries.
Opioid treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Network Provider	A Claims Administrator network contracted provider that is not contracted specific to this Plan; and Nonparticipating Providers.

Out-of-pocket maximum	The most each person must pay each applicable plan or calendar year toward the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the applicable plan or calendar year. The Benefit Chart lists the out-of-pocket maximum amounts.
Outpatient behavioral health treatment facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Partial programs	An intensive structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.
Participating Pharmacy	A pharmaceutical provider that participates in a network for the dispensing of prescription drugs.
Participating Provider	A provider who has entered into a specific network contract with the Claims Administrator.
Pharmacy value based benefit design	A program designed to reward ongoing appropriate drug usage by providing reduced member cost sharing for medications in specific categories or drug classes.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Place of service	Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers. 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.
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 drug deductible	A separate deductible amount that must be satisfied prior to any benefit for prescription drugs. The amount of this deductible is shown in the Benefit Chart.
Prescription drug out-of-pocket maximum	The most you must pay toward the allowed amount for covered prescription drugs per applicable plan or calendar year. After you reach the prescription drug out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered prescription drugs for the rest of the applicable plan or calendar year. The Benefit Chart lists the prescription drug out-of-pocket maximum amount.
Prescription drugs	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
Provider	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.
Qualifying creditable coverage	Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, Medicare, MinnesotaCare, Medical Assistance (Medicaid), General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; the Children's Health Insurance Program (CHIP), or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioners of Commerce or Health.
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 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	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. 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.
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 these medications, there must be documented evidence that you have tried another eligible medication in the same or different drug class before the step therapy medication will be paid under the drug benefit.

Substance abuse and/or addictions

Alcohol, drug dependence or other addictions as defined in the most current 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

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

Supplies do not include such things as:

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

Surrogate pregnancy

An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

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