MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Summary of Benefits

2020-2021

Your health care coverage through the State Employee Group Insurance Plan

Minnesota Advantage Health Plan

This document is current as of January 1, 2020.

Emergency Medical Care

Be prepared for the possibility of a Medical Emergency before the need arises by knowing Your Primary Care Clinic (PCC) procedures for care needed after regular clinic hours.

Name of Your PCC: _____

Address: _____

Phone: _____

Name of Hospital used by
Your PCC: _____

Address: _____

Phone: _____

If You face a Medical Emergency, go immediately to the nearest emergency facility.

Please also refer to page 31 for information regarding services provided to Advantage Members by convenience clinics

MANAGEMENT AND BUDGET

To Participants in the State Employee Group Insurance Program (SEGIP) health Plans:

We are pleased to provide to You the 2020-2021 Summary of Benefits. This important reference document provides a detailed description of the medical coverage available to You through the Minnesota Advantage Health Plan ("Advantage") and information on the pharmacy benefit structure administered through CVS Caremark. It also details the levels of cost-sharing including different office visit Copayment levels depending upon whether You completed the Health Assessment (and opted-in for health coaching, if eligible) during each Open Enrollment. Finally, this document is Your source for information on eligibility provisions and Your rights to continue these benefits for a limited period of time when coverage terminates for You or one of Your dependents.

Please take a moment to understand the cost-sharing provisions of Advantage that are described in the Summary. These include the Copayments, Coinsurance, and Deductibles applicable to the cost level of Your Primary Care Clinic.

We hope You will also fill in the information on the inside of the Summary's front cover so that You have the necessary information to receive Treatment quickly should a Medical Emergency arise.

If You have questions about Your coverage, You may call a Customer Service Representative at the Claims Administrator You chose during Open Enrollment at one of the following numbers. Also included is the number for CVS Caremark, the Plan's pharmacy benefit manager.

BlueCross BlueShield MN	(651) 662-5090 or (800) 262-0819
HealthPartners	(952) 883-7900 or (888) 343-4404
PreferredOne	(763) 847-4477 or (800) 997-1750
CVS Caremark	(844) 345-3234

2020 Minnesota Advantage Health Plan Schedule of Benefits

2020 Benefit Provision	**Cost Level 1 -** You Pay	**Cost Level 2 -** You Pay	**Cost Level 3 -** You Pay	**Cost Level 4 -** You Pay
A. **Preventive Care Services** • Routine medical exams, cancer screening • Child health preventive services, routine immunizations • Prenatal and postnatal care and exams • Adult immunizations • Routine eye and hearing exams	Nothing	Nothing	Nothing	Nothing
B. **Annual First Dollar Deductible** (single/family)	$250/500	$400/800	$750/1500	$1500/3000
C. **Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care** • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in & out of network)	$30/35* copay per visit Annual deductible applies	$35/40* copay per visit Annual deductible applies	$65/70* copay per visit Annual deductible applies	$85/90* copay per visit Annual deductible applies
D. **In-network Convenience Clinics & Online Care** (deductible waived)	$0 copay	$0 copay	$0 copay	$0 copay
E. **Emergency Care (in or out of network)** • Emergency care received in a hospital emergency room	$100 copay Annual deductible applies	$100 copay Annual deductible applies	$100 copay Annual deductible applies	25% coinsurance Annual deductible applies
F. **Inpatient Hospital Copay** (waived for admission to Center of Excellence)	$100 copay Annual deductible applies	$200 copay Annual deductible applies	$500 copay Annual deductible applies	25% coinsurance Annual deductible applies
G. **Outpatient Surgery Copay**	$60 copay Annual deductible applies	$120 copay Annual deductible applies	$250 copay Annual deductible applies	25% coinsurance Annual deductible applies
H. **Hospice and Skilled Nursing Facility**	Nothing	Nothing	Nothing	Nothing
I. **Prosthetics, Durable Medical Equipment**	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance Annual deductible applies
J. **Lab** (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	10% coinsurance Annual deductible applies	10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies

K. **MRI/CT Scans**	10% coinsurance Annual deductible applies	15% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies	30% coinsurance Annual deductible applies

L. **Other expenses not covered in A-K above, including but not limited to:**
• **Ambulance**
• **Home Health Care**
• **Outpatient Hospital Services (non-surgical)**
  • Radiation/chemotherapy
  • Dialysis
  • Day treatment for mental health and chemical dependency
  • Other diagnostic or treatment related outpatient services
	5% coinsurance
	Annual deductible applies
		5% coinsurance
		Annual deductible applies
			20% coinsurance
			Annual deductible applies
				25% coinsurance
				Annual deductible applies

M. **Prescription Drugs** 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.	$18/30/55	$18/30/55	$18/30/55	$18/30/55
N. **Plan Maximum Out-of-Pocket Expense for Prescription Drugs** (excludes PKU, Infertility, growth hormones) (single/family)	$1050/2100	$1050/2100	$1050/2100	$1050/2100
O. **Plan Maximum Out-of-Pocket Expense** (excluding prescription drugs) (single/family)	$1700/3400	$1700/3400	$2400/4800	$3600/7200

*Employees who complete the Health Assessment during Open Enrollment and agree to a health coaching call receive the lower office visit copayment for themselves and covered dependents. Employees hired after the close of Open Enrollment will automatically receive the lower copayment.

This chart applies only to in-network coverage. Point-of-Service (POS), coverage is available only to members whose permanent residence is outside both the State of Minnesota and the Advantage plan's service area. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical]; and college students. It also applies to dependent children and spouses permanently residing outside the service area. Members enrolled in this category pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance to the out-of-pocket maximum described in Section O above. Members pay the drug copayment described at Section M above to the out-of-pocket maximum described at Section N. This benefit must be requested.

The Advantage Plan offers a standard set of benefits regardless of the selected carrier. There are differences in how each carrier administers the benefits, including the transplant benefit, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.

Introduction

This Summary of Benefits is intended to describe Your medical and pharmacy coverage under the State Insurance Group Health Plan (the "Plan") for insurance year 2020. This booklet describes the eligibility provisions of the Plan, the events which can cause You to lose coverage, Your rights to continue coverage when You or Your dependents are no longer eligible to participate in the Plan. You will find a description of the medical and pharmacy benefits covered under the Plan in this Summary of Benefits, including Treatment of Illness and injury through office visits, surgical procedures, Hospitalizations, lab tests, mental health and chemical dependency programs, Prescription Drugs, therapy and other Treatment methods. You will also read about the levels of coverage under the Plan, the Deductibles, Coinsurance and Copayments that are Your responsibility and the requirements for pre-authorization and case management which apply to certain benefit coverages. This booklet also explains which events during the year might allow You to add a dependent or modify Your coverage.

There are three companies which administer medical benefits under the Plan: BlueCross BlueShield of Minnesota (BCBSM), HealthPartners, and PreferredOne. At Open Enrollment time each year You have the opportunity to select the benefit arrangement and the company administering and medical benefits You want to use for the year. CVS Caremark is the pharmacy benefit manager for the Plan.

For further information You may contact the State Employee Group Insurance Program (SEGIP), Your Designated Department Insurance Representative (DDIR) or Your Human Resources office. You may also contact the Claims Administrator You have selected or the Plan's pharmacy benefit manager at the appropriate address below:

BLUECROSS BLUESHIELD

BlueCross BlueShield of Minnesota
3535 Blue Cross Road
Eagan, MN 55122
(651) 662-5090
(800) 262-0819
TTY (651) 662-8700
(888) 878-0137 TDD

PREFERREDONE

PreferredOne Administrative Services, Inc.
P.O. Box 59212
Minneapolis, MN 55459-0212
(763) 847-4477
(800) 997-1750
Hearing Impaired Individuals – (763) 847-4013

HEALTHPARTNERS

HealthPartners Administrators, Inc.
8170 - 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
(952) 883-7900
(888) 343-4404
TTY (952) 883-5127

CVS Caremark

P.O. Box 52136
Phoenix, AZ 85072-2136
(844) 345-3234

Specific information about the Plan

Employer:	State of Minnesota
Name of the Plan:	The Plan shall be known as the State Employee Group Insurance Plan which provides medical benefits to certain eligible participants and their dependents.
Address of the Plan:	State of Minnesota Minnesota Management and Budget Employee Insurance Section 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155
Plan Year:	The Plan year begins with the payroll period designated by the Plan Sponsor.
Plan Fiscal Year Ends:	December 31
Plan Sponsor:	State of Minnesota Minnesota Management and Budget Employee Insurance Section 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155
Agent for Service of Legal Process:	Lorna Smith, Director Minnesota Management and Budget Employee Insurance Section 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155
Funding:	Claims under the Plan are paid from the assets of a trust of the Employer.

Claims Administrators:

BLUECROSS BLUESHIELD
BlueCross BlueShield of Minnesota
3535 Blue Cross Road
Eagan, MN 55122
(651) 662-5090
(800) 262-0819
TTY (651) 662-8700
(888) 878-0137 TDD

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(800) 997-1750
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HEALTHPARTNERS
HealthPartners Administrators, Inc.
8170 - 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
(952) 883-7900
(888) 343-4404
TTY (952) 883-5127

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
(844) 345-3234

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I. Member bill of rights for network services

A. RIGHTS OF MEMBERS

1. Members have the right to available and accessible services including emergency services 24 hours a day and seven days a week.
2. Members have the right to be informed of health problems, and to receive information regarding Treatment alternatives and risks which is sufficient to assure informed choice.
3. Members have the right to refuse Treatment, and the right to privacy of medical or dental and financial records maintained by the Plan manager, the sponsor and health care Providers, in accordance with existing law.
4. Members have the right to file a grievance with the sponsor (the Employee Insurance Section of Minnesota Management and Budget) and the right to initiate a legal proceeding when experiencing a problem with Plan or health care Providers.
5. Members have the right to a grace period of 30 days for each payment due for coverage under the Plan, when falling due after the first payment due for coverage, during which period coverage under the Plan shall continue in force.
6. Medicare enrollees have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.
7. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered under the Plan.
8. Members have the right to an external review of denied claims or services if the Member's claim is denied initially and receives an adverse determination at all levels of internal appeal to the Claims Administrator (see Section XII).

B. RESPONSIBILITIES OF MEMBERS

1. Read this Summary of Benefits and the enrollment materials completely and comply with the stated rules and limitations.
2. Contact Providers to arrange for necessary medical appointments.
3. Pay any applicable Copayments, Deductibles and contributions as stated in this Summary of Benefits.
4. Identify Yourself as a Member by presenting Your identification card whenever You receive Covered Services under the Plan.

II. Introduction to Your coverage

Minnesota Management and Budget or its successor agency ("Sponsor") as the sponsor and administrator, has established a Group Health Plan ("the Plan") to provide medical benefits for covered contract holders and their covered dependents ("Members"). This Plan is "self-funded" which means that the Sponsor pays the claims from a trust established to fund these benefits as expenses for Covered Services as they are incurred. The Plan is described in the Summary of Benefits ("SB"). The Sponsor has contracted with BCBSM, HealthPartners and PreferredOne to provide a network of health care Providers, claims processing, pre-certification and other administrative services. The Sponsor has also contracted with CVS Caremark to manage pharmacy benefits associated with the Plan. However, the Sponsor is solely responsible for payment of Your eligible claims.

The Sponsor, by action of an authorized officer or committee, reserves the right to change or terminate the Plan. This includes, but is not limited to, changes to contributions, Deductibles, Copayments, Out-of-Pocket Maximums, benefits payable and any other terms or conditions of the Plan. The decision to change the Plan may be due to changes in federal or state laws governing health and welfare benefits, or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another Plan or the Plan may be split into two or more parts.

The Sponsor has the power to delegate specific duties and responsibilities. Any delegation by the Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

A. Claims Administrators

BCBSM, HealthPartners and PreferredOne provide certain administrative services in connection with the Plan. As external administrators, BCBSM, HealthPartners and PreferredOne are referred to as the Claims Administrators. CVS Caremark is the Claims Administrator for the pharmacy benefits. The Claims Administrator may arrange for additional parties to provide certain administrative services, including claim processing services, subrogation, utilization management, medical management, and complaint resolution assistance. The Claims Administrator has the discretionary authority to determine a Member's entitlement to benefits under the terms of the Plan including the authority to determine the amount of payment for claims submitted and to constitute the terms of each Plan. However, the Claims Administrator may not make modifications or amendments to the Employee Plan. Eligible services are covered only when Medically Necessary for the Treatment of a Member. Decisions about medical necessity, restrictions on access, and appropriateness of Treatment are made by the Claims Administrator's medical director or his or her designee.

B. Summary of Benefits ("SB")

This SB is Your description of the Group Health Plan ("this Plan"). It describes the Plan's benefits and limitations for Your health care coverage. Please read this entire SB carefully. Many of its provisions are interrelated; reading just one or two provisions may give You incomplete information regarding Your rights and responsibilities under the Plan. Many of the terms used in the SB have special meanings and are specifically defined in the SB and are capitalized.

Included in this SB is a Benefit Chart that states the amount of cost sharing associated with Covered Services. Amendments that are included with this SB or sent to You at a later date are fully made a part of this SB.

This Plan is maintained exclusively for covered participants and their covered dependents. Each Member's rights under the Plan are legally enforceable.

C. Financial and Administrative Service Agreement

This SB, together with the signed Financial and Administrative Services Agreement between Sponsor and the Claims Administrator, constitutes the entire agreement between the Claims Administrator and Sponsor. A version of the Financial and Administrative Services Agreement is available for inspection at the Employee Insurance Section of Minnesota Management and Budget (MMB).

D. Your Identification Card

The Claims Administrator issues an identification (ID) card to Members containing coverage information. Please verify the information on the ID card and notify the Customer Service Unit of the Claims Administrator if there are errors. If the Primary Care Clinic (PCC) on Your ID card is incorrect, please contact the Claims Administrator immediately. If You do not notify the Claims Administrator within 30 days after receipt of Your ID card that You have been assigned an incorrect PCC, You must wait until the first of the following month to make a change to the appropriate PCC. It is important that Your name is spelled correctly and that Your identification number is correct. If any ID card information is incorrect, claims or bills for Your health care may be delayed or temporarily denied.

You will also receive an identification card from CVS Caremark, which must be used when receiving pharmacy services.

You must show Your ID card every time You request health care or pharmacy services from participating Providers. If You do not show Your card, the participating Provider has no way of knowing You are a Member and may bill You for the services.

E. Provider Directory

A Provider directory is available through the MMB website (www.mn.gov/mmb), listing the participating Providers and facilities available to You. Access requirements may vary according to the PCC You select. Emergency care is available 24 hours a day, seven days a week.

F. Conflict with Existing Law

In the event that any provision of this SB is in conflict with applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

G. Records

Certain facts are needed for Plan administration, claims processing, utilization management, quality assessment and case management. By enrolling for coverage under the Plan, You authorize and direct any person or institution that has provided services to You to furnish the Sponsor or any of its agents or designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to You. Upon obtaining Your signed and dated consent, the Sponsor or its agents or designees will have the right to release any and all records concerning health care services, which are necessary to implement and administer the terms of the Plan or for appropriate medical review or quality assessment. Upon obtaining Your signed and dated consent, the Sponsor and its agents or designees will maintain confidentiality of such information in accordance with existing law. This authorization applies to You and each dependent, regardless of whether each dependent signs the application for enrollment. (Also see Section XVII, Medical Data Privacy.)

H. Clerical Error

You will not be deprived of coverage under the Plan because of a clerical error. However, You will not be eligible for coverage beyond the scheduled termination of Your coverage because of a failure to record the termination.

III. Coverage information

A. COVERAGE DESCRIPTION

1. How to Obtain Health Care Services

a) Coverage Under The Minnesota Advantage Health Plan ("Advantage")

Each contract holder participating in the Minnesota Advantage Health Plan elects a Claims Administrator and a Primary Care Clinic (PCC) during his or her initial enrollment. Each PCC is associated with a Claims Administrator (Blue Cross Blue Shield of Minnesota, HealthPartners, or PreferredOne). Dependents may be enrolled in Primary Care Clinics that are in different Cost Levels, but they must be enrolled through the same Claims Administrator as the contract holder.

The Primary Care Clinics available through each Claims Administrator are assigned to a Cost Level. The Copayments, annual Deductibles and Coinsurance amounts You pay for medical services will vary depending upon the Cost Level to which Your PCC belongs.

Members may change Claims Administrators only during the annual open enrollment period or because of a status change permitted by law. Members may elect to change clinics as often as the

Plan Administrator permits. For BCBSM, HealthPartners and PreferredOne, changes can be received any time during the month to be effective the first of the following month. PCC changes may not be made during the time You are Hospitalized or receiving inpatient services.

Coverage for medical care is summarized in the Benefits Schedule on page 2, and detailed in the Benefit Chart, Section IV.A – II. Please review these sections carefully so that You understand any charges (such as office visit Copayments, annual Deductibles, and Coinsurance amounts) for which You will be responsible.

b) Services From Your Primary Care Clinic (PCC)

Your PCC will provide, or arrange through referral to a participating Provider, all Medically Necessary health care services. In general, Your PCC will not make a referral for services that Your PCC can provide. For information regarding referrals, see "Referrals from Your Primary Care Clinic," following this section. If You do not make a selection, the Claims Administrator may assign a PCC or physician for You.

The Plan requires the designation of a Primary Care Clinic. You have the right to designate any Primary Care Clinic who participates in the network of the Claims Administrator You have chosen and who is available to accept You or Your family Members. Under certain circumstance until You make this designation, the State of Minnesota may designate one for You. For information on how to select a Primary Care Clinic, and for a list of the participating Primary Care Clinics, contact the Claims Administrators listed on page 1, or Minnesota Management and Budget at 651-355-0100.

If You have qualified dependents covered by this Plan, each family Member may choose his or her own PCC.

Female employees and/or covered female dependents may obtain direct access without a referral or any other Prior Authorization from their Primary Care Clinic (PCC) or any other person to an obstetrical or gynecological health care professional in the network of Your chosen Claims Administrator who specializes in obstetrics or gynecology for the following services: annual preventive health examinations and any Medically Necessary follow-up visits, maternity care, evaluation and necessary Treatment for acute gynecologic conditions or emergencies. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved Treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Your chosen Claims Administrator.

You also have the option of self-referring to a mental health or chemical health care Provider, vision care Provider, or chiropractor who participates in the self-referral network of the Claims Administrator You have selected. Please refer to Your Provider directory or call your Claims Administrator with questions regarding self-referral. Providers in such self-referral networks do not have referral authority. For children, you may designate a participating pediatrician as the primary care provider.

Please refer to Maternity, Physician Services and Preventive Care for a description of services that can be obtained without a referral. A listing of the eligible Providers in the network associated with Your PCC is available from the Claims Administrator.

You are responsible for notifying Your PCC of any cancellation of appointments in a timely manner. If You miss or cancel an office visit less than 24 hours before an appointment, Your PCC may bill You for an office Copay for the service; such Copay would not be covered by the Plan.

c) Referrals From Your Primary Care Clinic

Your PCC determines when Hospitalization or the services of another Plan Provider are necessary. If You require Hospitalization, Your PCC will make arrangements for Your care and notify the Claims Administrator that Your Admission has been scheduled. When You need to see a specialist, Your PCC will notify the Claims Administrator of the referral by submitting the name of the specialist, the number of authorized visits, and the length of time allowed for those visits. (Under the HealthPartners Plan, Members can see any specialist associated with their care network without a referral. Please call HealthPartners for further information.) Providers to whom You are referred do not have further referral authority. Be sure to follow these referral protocols carefully, whether for an inpatient or outpatient service, to ensure that your claim is covered correctly. Contact your PCC if you have questions about your admission, the facility to which you have been directed, or the specialist to whom you have been referred.

You may apply for a standing referral to a health care Provider who is a specialist if a referral to a specialist is required for coverage. Your PCC remains responsible for coordinating Your care.

Coverage will be provided only for the services outlined in the written referral or standing referral authorization.

Pursuant to Minn. Stat. Sec. 62Q.58, a standing referral must be given to a patient who requests a standing referral and has any of the following conditions:

- A chronic health condition
- A life-threatening mental or physical Illness
- Pregnancy beyond the first trimester
- A degenerative disease or disability
- Any other disease or condition of sufficient seriousness and complexity to require Treatment by a specialist
- A standing referral may be granted for no more than 365 days – it may not be open-ended. The standing referral can never cover a period of time longer than the patient's contract. When a standing referral expires, the primary care doctor or clinic may establish another standing referral.
- If a patient who has a referral or standing referral changes Primary Care Clinics, the referral or standing referral expires as of the date of the clinic change. The patient's new primary care doctor or clinic must establish a new referral or standing referral.

When a referral for care is made in advance by Your PCC, coverage is provided according to the terms of this SB. The referral will indicate a length of time for approval. Any service not performed in the specified time frame will need to be re-referred.

Referrals are not given to accommodate personal preference, family convenience, geographical location, or other non-medical reasons. Your PCC is not obligated to refer services that You have chosen to receive outside Your PCC without Your PCC's approval. If You request a referral, and that request is denied, You may appeal directly to the Claims Administrator. Call Customer Service for direction.

If You change Your PCC, referrals from Your former PCC are invalid after the date of the change. Your new PCC will determine the necessity of any further referrals.

All referrals to non-participating Providers, with the exception of emergency services and urgent care center services and those services specified at Section IV.EE., require approval prior to the service.

d) Charges That Are Your Responsibility

When You use Your PCC You are responsible for:

i) Copays; the level of Your Copayment is based on whether You completed the Health Assessment and opted in for health coaching during each annual Open Enrollment. Please see Section VII for additional information about the Health Assessment.
ii) Deductibles and Coinsurance;
iii) Charges for non-Covered Services; and
iv) Charges for services that are Investigative or not Medically Necessary.

e) Services Not Authorized By The Primary Care Clinic For You Or Your Dependent – In Minnesota or Outside The State of Minnesota

Except for the services listed in Sections III.A.l.i and IV. EE, there is NO COVERAGE for non-emergency and non-urgent services not authorized by Your Primary Care Clinic, and You must pay all charges.

f) Unauthorized Provider Services Received for a Nonparticipating Provider at Participating Facilities

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the Provider of care. For example, some Hospital-based Providers (e.g., anesthesiologists) or independent Lab Providers may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the Allowed Amount and the Provider's billed charges. However, in circumstances where you needed care such as in a participating hospital and were not able to choose the Provider who rendered such care (Nonparticipating Providers in a participating hospital or your Physician sending lab samples to a Nonparticipating Lab), Minnesota law provides that you may not be responsible for any amounts above what would have been required to pay (such as cost sharing and deductibles) had you used a Participating Provider, unless you gave advance written consent to the Nonparticipating Provider. If you receive a bill from a Nonparticipating Provider while using a participating hospital or facility, and you did not provide written consent to receive the Nonparticipating Provider's Services, you should submit the bill to your Claims Administrator for processing. If you have questions, please contact Member Service. The extent of reimbursement in certain Medical Emergency circumstances may also be subject to state and federal law – please refer to "Emergency Care" for coverage of benefits.

g) Emergency Medical Care and Notification of Emergency Admission

Be prepared for the possibility of an emergency before the need arises by knowing Your Primary Care Clinic procedures. Determine the telephone number to call, the Hospital Your Primary Care Clinic uses, and other information that will help You act quickly and correctly. Keep this information in an accessible location in case an emergency arises.

If the situation is life-threatening call 911.

If the situation is an emergency, You should go to the nearest medical facility. A Medical Emergency is Medically Necessary care of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which a reasonable layperson believes to be 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.

If the situation is not an emergency, please call Your PCC before receiving care. Each PCC has staff on call 24 hours a day, seven days a week. When You call You will be directed to the appropriate place of Treatment for Your situation.

If You are admitted to a facility for an emergency service please notify Your Primary Care Clinic as soon as possible so that Your PCC can coordinate all subsequent care. Your Primary Care Clinic may decide to transfer You to its designated Hospital. In that case, the Plan will provide for the ambulance used for the transfer, according to the ambulance benefit listed in Section IV.I.

Emergency room services are subject to the Copay listed in the Benefit Chart unless You are admitted within 24 hours for the same condition. Follow-up care for emergency services (e.g., suture removal, cast changes, etc.) is not an emergency service and must be provided or authorized by Your PCC to receive the highest level of coverage.

h) Urgent Care

Urgent care problems include injuries or Illnesses such as sprains, high fever or severe vomiting which are painful and severe enough to require urgent Treatment, but are not life-threatening. You may seek assistance at any urgent care without contacting Your own PCC.

All Members may receive urgent care while away from home, but for routine care please see Section V. A, Authorized Care Outside the Service Area.

i) Out of Area Coverage

Permanent Residence. For purposes of this section

- Permanent Residence is the place where the employee intends to make his/her home for a permanent or indefinite period of time.
- Alternatively, Permanent Residence is where the employee lives for at least 183 days per year.

National Preferred Provider Organization (PPO). Each Claims Administrator offers a PPO through which all eligible employees and dependents are eligible to receive discounted services outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. (Coverage is limited to urgent and emergency care for employees whose Permanent Residence is within the State of Minnesota and the service area of the Minnesota Advantage Health Plan. Coverage for other employees is as outlined below.)

Point-of-Service (POS). The POS benefit is available to employees, early retirees, former employees, former employees with disabilities, and COBRA enrollees whose Permanent Residence is outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan. It is also available to employees temporarily residing outside Minnesota on temporary or paid leave (including sabbatical leave) and all dependent children (including college students) and spouses and ex-spouses living out of area. The benefit schedule includes a $350 single/$700 family Deductibles and 30% Coinsurance paid up to the Allowed Amount; Members using this benefit may be responsible for the difference between the Allowed Amount and the billed charge. These employees and their dependents may receive Provider discounts when they use the PPO of the Claims Administrator with whom they are enrolled. (Parents of college students eligible for this benefit are asked to notify their Claims Administrator of their child's eligibility.) Members eligible for this benefit will be asked to designate a Primary Care Clinic within the service area, and when in-area, they are covered through the PCC at the cost level they have chosen.

Access for Point of Service (POS) benefits must be requested by providing the permanent address outside the service area to SEGIP and by calling your Claims Administrator to request access to POS.

Children living out-of-area with ex-spouses (in or out of state). Eligible children living out-of-area with an ex-spouse and receiving benefits under this provision as of December 31, 2003, may receive Cost Level 2 benefits in the area of their Permanent Residence if they obtain services from the PPO of the Claims Administrator with whom they are enrolled. If a Plan Provider is not available in their area, the dependent may receive Cost Level 2 benefits from any licensed Provider in their area. If a PPO Provider is available but not used, benefits will be paid at the POS level described above.

Employees who live and work out-of-area. Employees whose Permanent Residence and principal work location are outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan may receive Cost Level 2 benefits in the area of their Permanent Residence if they obtain services from the PPO of the Claims Administrator with whom they are enrolled. If a PPO Provider is not available in their area, they may receive Cost Level 2 benefits from any licensed Provider in their area. If PPO Provider is available but not used, coverage will be limited to point-of-service benefits ($350/$700 Deductibles, 30% Coinsurance).

B. COVERAGE ELIGIBILITY AND ENROLLMENT

Statement of Fraud or Intentional Misrepresentation

Each Member must notify the Plan Administrator immediately of the date the Member knew or should have known that fraudulent or misrepresented information was either:

a) Contained in the enrollment information provided to the Plan Administrator (or the Plan Administrator's representatives) pertaining to the Member or any individual related to the Member receiving or seeking benefits under the Plan, or
b) Related to a claim for benefits is or has become incorrect due to an affirmative statement of information, an omission of information, or a change in circumstances.

The Plan Administrator may rescind or cancel the coverage of a Member and/or each individual enrolled in the Plan under the Member upon thirty (30) days prior written notice if the Plan Administrator determines that the Member or individual made an intentional misrepresentation of material fact or was involved in fraud concerning any matter relating to eligibility for coverage or claim for benefits under the Plan.

Coverage for each individual identified in a Notice of Rescission of Coverage will be rescinded as of the date specified in the Notice of Rescission of Coverage, which may be to the effective date of individual's coverage. The Member and any individual involved in the misrepresentation or fraud may be liable for all claims paid by the Plan on behalf of such individuals.

1. Employee eligibility for medical benefits

Minnesota Management and Budget (MMB) determines the eligibility of state employees and dependents subject to collective bargaining agreements and compensation plans and state and federal laws and regulations. Eligibility rules and requirements may change during a Benefit Year. The Claims Administrator agrees to accept the eligibility decisions of MMB as binding.

MMB requires You to submit legal documentation acceptable to MMB to establish the eligibility of Your dependents including the appropriate MMB certification form for evaluation of eligibility. If you do not provide documentation acceptable to MMB within the stated deadline or knowingly provide false information as proof of eligibility, Your dependents may be removed from the plan, and You may be required to reimburse the Plan for claims the Plan paid on behalf of the ineligible dependent during the period of ineligibility.

Determination of eligibility

An employee's eligibility is first determined by the terms of the applicable collective bargaining agreement or compensation plan. If an employee is not eligible based on the terms of the applicable collective bargaining agreement or compensation plan then the state and federal law and regulations will be applied.

If You are not eligible based on the applicable collective bargaining agreement or compensation plan and if required by federal law or regulation the following terms will be applied:

Type of appointment	Eligibility for medical coverage
Full-time: anticipated to work 30 or more hours for more than 90 days	Full employer contribution
Part-time: anticipated to work less than 30 or more hours per week	Coverage as allowed under the applicable collective bargaining agreement or compensation plan
Short term: anticipated to work less than 90 days	No coverage
Seasonal: anticipated to work up to six months and was appointed to work for a Season*	Coverage as allowed under the applicable collective bargaining agreement or compensation plan

* A Season will begin at approximately the same part of the year, such as summer or winter and may be defined by the task such as tax season or plowing season. In rare circumstances, a Season may be extended beyond six months and the incumbent employee will still be treated as a Seasonal Employee.

Determination of Full-time

For benefit eligibility purposes, Full-time is defined as 30 or more hours per week (or 130 hours per month). At the time of appointment, the appointing authority will make a good faith determination of Your status as a Full-time employee. Thereafter, the State will use the Look Back Method, (see Section XV), to determine Full-time status.

Change in Employment Status

You experience a Change in Employment Status when the number of hours You are expected to provide on an ongoing basis either increases from less than 30 hours per week to 30 or more hours per week or decreases from 30 or more hours per week to less than 30 hours per week. If the number of hours You are expected to provide:

- Decreases to less than 30 hours per week: Then You may no longer be eligible for the full employer contribution. However, if You were considered Full-time for medical coverage purposes Your employer may be required to measure Your hours for three full calendar months to prove Your status as a not Full-time employee before Your eligibility may be changed or your agency may wait until your Stability Period ends.
- Increases to more than 30 hours per week: Then You may become eligible for the full employer contribution.
    - If You are eligible for the full employer contribution under the applicable collective bargaining agreement or compensation plan the coverage level will be changed without a measurement period.

- If Your position is not eligible under the applicable collective bargaining agreement or compensation plan then You must be measured for three full calendar months, or maintain the contribution level thru the remainder of the Stability Period, to prove You have become Full-time.

2. Waiving medical coverage

You may choose to waive medical coverage. If You are eligible for the full employer contribution and choose to waive medical coverage You must submit a Waiver of Medical Coverage form (mn.gov/mmb-stat/segip/doc/Waiver_of_medical_coverage_form.pdf) and provide proof of other coverage by the end of Your enrollment period. If you do not submit the form and proof by the end of Your enrollment period you will be enrolled in medical coverage. If You waive medical coverage You can elect it again during the next Open Enrollment or midyear upon a permitted Qualified Life Event.

You will be required to provide confirmation that you wish to continue to waive your medical insurance during the annual Open Enrollment on the Employee Self-Service website. If you do not provide the annual confirmation to waive, you will be default enrolled into single medical insurance the first of the following plan year.

If You are eligible for a partial or no employer contribution You may waive medical coverage without providing the Waiver of Medical Coverage form and You will not need to show proof of other coverage. If You are already enrolled in the Advantage Health Plan with Your own policy and do not affirmatively waive coverage You will continue to be enrolled at Your current level. If you are not already enrolled You will not be enrolled in medical coverage unless You affirmatively enroll.

3. Eligible Dependents include the following:

a) Spouse.

The spouse of an eligible employee (if legally married under Minnesota Law). For the purposes of health insurance coverage, if that spouse works full-time for an organization employing more than one hundred (100) people and elects to receive either credits or cash (1) in place of health insurance or health coverage or (2) in addition to a health plan with a seven hundred and fifty dollar ($750) or greater deductible through his/her employing organization, he/she is not eligible to be a covered dependent.

b) Child.

Dependent child: A dependent child is an eligible employee's child to age 26. "Dependent child" includes an employee's: (1) biological child, (2) child legally adopted by or placed for adoption with the employee, (3) stepchild, and (4) foster child. For a stepchild to be considered a dependent child, the employee must be legally married to the child's legal parent. For a foster child to be considered a dependent child under this plan, the foster child must be placed with the employee or the employee's spouse by an authorized placement agency or by a judgment, decree or other court order; the employee and/or the employee's spouse must have full and permanent legal and physical custody.

c) Grandchild.

A dependent grandchild, to age twenty-five (25), is an eligible employee's unmarried dependent grandchild who: (a) is financially dependent upon the employee for principal support and maintenance and has resided with the employee continuously from birth or, (b) resides with the employee and is dependent upon the employee for principal support and maintenance, and the employee's unmarried child (the parent) is less than age nineteen (19). If a grandchild is legally adopted or placed in the legal custody (is a foster child) of the grandparent, they are covered as a dependent child under b) Child.

d) Disabled Child.

A disabled dependent child is an eligible child regardless of marital status, who was disabled prior to the limiting age or any other limiting term required for dependent coverage and who continues to be incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and is chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Claims Administrator by the employee or enrollee within thirty one (31) days of the child's attainment of the limiting age or any other limiting term required for dependent coverage. The disabled dependent is eligible to continue coverage as long as s/he continues to be disabled and dependent, unless coverage terminates under the contract.

e) Qualified Medical Child Support Order.

A child who is required to be covered by a Qualified Medical Child Support Order (QMCSO) is considered an eligible dependent.

f) Certain related adults and adult dependent children participating in SEGIP.

When these two categories of related adults each are eligible to participate in SEGIP one may cover the other as a dependent:

- When both spouses work for the state, or another organization participating in SEGIP, and are legally married to each other, one of the spouse may be covered as a dependent by the other spouse.
- When the participating employee's adult child (age 18 until 26) works for the state, or another organization participating in SEGIP, the adult child may be covered as a dependent by the parent.

In either situation, the employee who will be covered as a dependent must waive coverage by completing the Waiver of Medical Coverage – Enrolled on Another State Employee's Coverage (mn.gov/mmb-stat/segip/doc/Waiver_of_medical_coverage_form.pdf) within their initial enrollment period, during an Open Enrollment Period, or midyear upon a permitted Qualified Life Event. Enrollment and dependent verification must be completed within the appropriate time periods. Only one state employee can cover dependents in common.

The dependent/employee may move to His/Her own plan during the annual Open Enrollment or midyear upon a permitted Qualified Life Event. The dependent/employee will be required to enroll in His/Her own plan if the spouse/employee or parent/employee ceases to participate in SEGIP or when the adult child/employee reaches age 26 and is no longer eligible as a dependent.

g) Child Coverage Limited to Coverage Under One Employee.

If both parents work for the State, or another organization that participates in SEGIP, either parent, but not both, may cover the eligible dependent child or grandchild. This restriction also applies to two divorced, legally separated, or unmarried employees who share legal responsibility for their eligible dependent child or grandchild.

If two or more employees having dependents in common participate in SEGIP, only one of the employees may cover their dependents in common.

In the case where an employee/grandparent and an employee/parent both participate in SEGIP, if the parent has his or her own policy, the parent must cover the child. The child is not eligible under the grandparent's policy.

h) Other.

Any person who is required by federal or state law to be a covered dependent.

4. Initial Enrollment

If You are a newly-hired employee, You must make application to enroll Yourself and any eligible dependents, and such application must be received within 35 days of the date of hire. If You are newly-eligible for an employer contribution, You must make application within 30 days. You must make written application to enroll a newly acquired dependent and that application and any required payments must be received within 30 days of when You first acquire the dependent (e.g., through marriage). At the time of enrollment, You need to select a Primary Care Clinic. For information regarding choice of a clinic, see the section entitled "How to Obtain Health Care Services," "Services from Your Primary Care Clinic (PCC)," Section III.A.1.b.

5. Effective Date of Coverage

The initial effective date of coverage is the 35th calendar day after the first day of employment, re-hire or reinstatement. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change provided the employee has been employed for 35 consecutive days. You must be actively at work on the initial effective date of coverage, or coverage will be delayed until the employee returns to active payroll status. Notwithstanding the foregoing, if You are not actively at work on the initial effective date of coverage due to Your health status, medical condition, or disability, or that of Your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and the regulations related to that Section, coverages shall not be delayed.

If required by federal law or regulation You will not be required to satisfy a waiting period if you experience a break in service of less than 13 weeks (or 26 weeks if You work for an educational institution). However, if You have more than a 13 (or 26 week) break in service You will be required to satisfy a 35-day waiting period.

If You and Your dependents apply for coverage during an Open Enrollment period, coverage will become effective on the date specified by the MMB.

Adopted children are covered from the date of placement for the purposes of adoption.

A newborn child's coverage takes effect at the moment of birth.

For a former legislator enrolling in the Minnesota Advantage Plan, the effective date of coverage is the first day of the month following or coinciding with the date of the application.

For the purposes of this entire section, a dependent's coverage may not take effect prior to an employee's coverage.

6. Special Enrollment Periods

Special enrollment periods are periods when an eligible group member or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll, the eligible group member or dependent **must notify the Employee Insurance Section within 30 days** of the Qualified Life Event, except as noted in the chart below. When gaining a dependent a due to birth, adoption or placement for adoption there is no required notice period, however, you must pay all applicable premiums which would have been owed had you notified us within 30 days.

Special Enrollment Qualified Life Event	Coverage Effective Date
Spouse or dependent loss of Minimum Essential Coverage[1] (does not include loss due to failure to pay premiums or rescission)	Date of coverage loss
Spouse or dependent loss of eligibility for Group Health Plan coverage or Health Insurance Coverage	Date of coverage loss
Marriage, birth, adoption, placement for adoption or foster care	Date of marriage, birth, adoption, placement for adoption, or placement for foster care.
An individual gains or loses eligibility for Medicaid, MinnesotaCare, or Children's Health Insurance Program (CHIP), (notice must be received with 60 days of event)	Date of change in eligibility

[1] 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.

Mid-Year enrollment events allow you and Your dependents to make enrollment choices outside of the annual enrollment period or initial period of eligibility within 30 calendar days of the event specified below. In order to enroll, the eligible group member or dependent **must notify the Employee Insurance Section within 30 days** of the event, except as noted in the chart below.

Mid-Year Election Events	Coverage Effective Date
Spouse or dependent termination of employment or reduction in hours	Date of coverage loss
Former legislators can elect coverage at any time (a former legislators' eligible dependent may not be enrolled unless the former legislator is also enrolled in coverage)	First day of the month following the request for enrollment
Divorce	Date of coverage loss
Retirees can elect to change Claims Administrators 60 days immediately preceding effective date of retirement	First day of the month following retirement date
Move outside of service area if access to coverage is impacted	Varies

7. Late Enrollment

If You are a late entrant, (do not enroll during your enrollment period), You may enroll Yourself and any eligible dependents:

a) During the annual Open Enrollment period; or
b) During a special enrollment period.

8. Open Enrollment

You may enroll Yourself and any eligible dependents during the annual Open Enrollment period

9. Adding New Dependents

A written application is required to add a new dependent. Filing a claim for benefits is not sufficient notice to add a dependent. This part outlines the time periods for application and the date coverage starts. See Section III. B. 5 for effective dates of coverage.

a) Adding a spouse

A spouse is eligible on the date of marriage:

Health insurance may take effect on the day of Your marriage, You must submit an application for coverage within 30 days of the date of the marriage.

b) Adding newborns

An application for coverage should be completed and should include Your child's full name, date of birth, sex, social security number and relationship to the employee. Coverage will become effective on the date of birth. We request that You submit the application for coverage within 30 days from the date of birth, even if you do not have the social security number, as it can be provided upon receipt. Coverage for the child will become effective on the date of birth.

c) Adding children placed for adoption

i) Coverage for such child will take place on the date of placement, once You have applied for coverage.
ii) Failure to submit an application for the child will not alter the effective date of coverage but will result in claims service problems for the child.

In all cases, the application for coverage under the Plan must be requested in writing and must include the name, date of birth, sex, social security number and relationship to the employee. When adding a dependent due to a qualified life event you may enroll any/all eligible dependents.

10. Special termination of coverage outside of Open Enrollment

a) Reduction of Hours. An employee who was expected to average at least 30 hours of service per week may drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan (e.g., because the plan's eligibility provisions have been drafted to avoid penalties under Health Care Reform's Employer Shared Responsibility provisions). However, the change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage. The new coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped.

b) Health Insurance Exchange Enrollment (Exchange). An employee who is eligible to enroll in Exchange coverage (during an Exchange special or open enrollment period) may drop group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Exchange coverage that is effective no later than the day after the last day of the original coverage.

11. Termination of Coverage

Coverage for You and/or Your dependents will terminate on the earliest of the following dates, except that coverage may be continued in some instances as specified in Continuation of Coverage (see Section III, B,13).

a) For You and Your dependents, the date that either the Claims Administrator or Minnesota Management and Budget terminates the Plan.

b) For You and Your dependents, the last day of the month in which You retire, unless You and Your dependents elect to maintain coverage under this Plan or a separate Medicare contract.

c) For You and Your dependents, the last day of the month in which Your eligibility under this Plan ends.

d) For You and Your dependents, following the receipt of a written request, the coverage will end on the last day of the month in which a life event occurred. Approval to terminate coverage will only be granted if the request is consistent with a life event. Life events include, but are not limited to:

   i) loss of dependent status of a sole dependent;
   ii) death of a sole dependent;
   iii) divorce;
   iv) change in employment condition of an employee, spouse, or a dependent who is covered under another Employer's plan (date of life event is based on the date of change in employment status, not eligibility for insurance coverage);
   v) a significant change of spouse's or a dependent's insurance cost or existing insurance coverage (for example, coverage decrease or addition of a benefit package; and
   vi) Open Enrollment.

e) Consistent with Your ability to choose a health Plan on the basis of where You live or work. For an Enrollee, the date 30 days after notice by Claims Administrator, when the Enrollee no longer resides within the service area. For the purposes of this section, a dependent's address is considered to be the same as Your address when attending an accredited school on a full-time basis, even though the student may be located outside of the service area.

f) For a child covered as a dependent, the last day of the month in which the child is no longer eligible as a dependent, unless otherwise specified by MMB.

g) For a dependent, the effective date of coverage, if the employee or his/her dependent knowingly makes fraudulent misstatements regarding the eligibility of the dependent for coverage.

h) For an enrollee who is directly billed by the MMB, the last day of the month for which the last full premium was paid, when the enrollee fails to pay the premium within 30 days of the date the premium was billed or due, whichever is later.

i) For an enrollee who is directly billed by the Claims Administrator, the end of the month for which the last premium was paid, when the enrollee fails to pay the premium within 30 days of the date the premium is due.

j) An employee or dependent found to be ineligible will be dropped from coverage as of the date of ineligibility or, if the date of ineligibility has passed then, 30 days from the first of the next full month. If the employee or dependent was found eligible based on fraud or an intentional misrepresentation of a material fact then the loss of coverage will be retroactive to the first day of ineligibility. If the Plan Sponsor erroneously enrolled an employee or a dependent coverage may be terminated retroactively

to the first day of ineligibility if the Plan Sponsor obtains the written consent from the employee or dependent authorizing the retroactive termination of coverage.

12. Extension of Benefits

If You are confined as an inpatient on the date Your coverage ends due to the replacement of the Plan, the Plan automatically extends coverage until the date You are discharged from the Hospital or the date benefit 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 Plan terminates, and the employer obtains continuous group coverage with a new Claims Administrator or insurer.

13. Continuation

You have the right to temporary extension of coverage under the State Employees Group Insurance Program (the Plan). The right to continuation coverage was created by the federal Public Health Service Act (PHSA), as well as by certain state laws. Continuation coverage may become available to You and to qualified dependents who are covered under the Plan when You would otherwise lose Your group health coverage.

This notice generally explains continuation coverage, when it may become available to You and Your qualified dependents, and what You need to do to protect the right to receive it.

The Plan Administrator is the State of Minnesota, Minnesota Management and Budget, Employee Insurance Section. The Plan Administrator is responsible for administering continuation coverage.

Continuation Coverage

Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. In most cases, You have 60 days from the date of the qualifying event to select continuation of coverage. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect continuation coverage must pay the full cost of coverage plus a 2 percent administration fee based on the cost of Your premium from the date of coverage would have terminated. (The 2 percent fee is waived in the case of disabled employees who elect such coverage.)

There may be other health coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. COBRA eligibility does not limit or exclude your eligibility for a health coverage tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within their specified timeframe.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct; or
4. You become divorced from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct; or
4. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the State of Minnesota, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is continuation coverage available?

The Plan will offer continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the Plan Administrator must be notified of the qualifying event within 30 days following the date coverage ends.

You must give notice of some qualifying events

For other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator in writing. The Plan requires You to notify the Plan Administrator within 60 days of the qualifying event occurs. You must send this notice to: Minnesota Management and Budget, SEGIP, 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN, 55155. Failure to provide notice may result in the loss of Your ability or the ability of Your dependent to elect continuation coverage.

How is continuation coverage provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect continuation coverage on behalf of their children. For each qualified beneficiary who elects continuation coverage, that coverage will begin on the date that Plan coverage would otherwise have been lost.

Continuation coverage is a temporary continuation of coverage.

- When the qualifying event is a dependent child losing eligibility as a dependent child, continuation of medical coverage lasts for up to 36 consecutive months.

- When the qualifying event is the death of the employee or divorce, continuation of medical coverage may last indefinitely.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 consecutive months before the qualifying event, continuation of medical coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).
- Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage generally lasts for only up to a total of 18 consecutive months. This 18-month period of continuation coverage can be extended if a second qualifying event occurs.

Second qualifying events

1. Extension of 18-month period of continuation coverage

If You or a Qualified Beneficiary experiences another qualifying event while receiving 18 months of continuation coverage, the spouse and dependent children in Your family can get additional months of health continuation coverage, up to a combined maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and dependent children if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Minnesota Management and Budget, SEGIP, 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN, 55155.**

2. Disability extension of 18-month period of continuation coverage

If You or a qualified dependent covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your qualified dependents can receive up to an additional 11 months of health continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of continuation coverage. This notice should be sent to: the Minnesota Management and Budget, SEGIP, 400 Centennial Office Building, 658 Cedar Street, St. Paul, MN, 55155.

Continuation coverage for employees who retire or become disabled

There are special rules for employees who become disabled or who retire. It is Your responsibility to contact Your agency's Human Resources office or Minnesota Management and Budget to become informed about those rules.

If You have questions

If You have questions about Your continuation coverage, You should contact Minnesota Management and Budget, Your agency's Human Resources office, or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep the Employer Informed of Address Changes

In order to protect Your rights and those of Your qualified dependents, You should keep the Employer informed of any changes in Your address and the addresses of qualified dependents. You should also keep a copy, for Your records, of any notices You send to the Employer or the Plan Administrator.

Cost Verification

Your employer will provide You or Your eligible dependents, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

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 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 adjustment 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 Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

14. Choosing a Claims Administrator

Active employees and their dependents may select a Claims Administrator based upon either work location or where they live. All other enrollees must choose a Claims Administrator based upon where they live.

15. Retirement

An employee who is retiring from state service or any group that is eligible to participate in the SEGIP and who is eligible to maintain participation in the SEGIP as determined by MMB may, consistent with state law, indefinitely maintain health coverage with the SEGIP by filling out the proper forms with their agency within 30 days after the effective date of their retirement.

If a retiring employee fails to make a proper election within the 30-day time period, the retiring Employee may continue coverage for up to 18 months in accordance with state and federal law. See item 13 for information on Your continuation rights.

In any event, failure to pay the premium will result in termination of coverage. Once coverage has been terminated for any reason, voluntary or involuntary, the retiree, early retiree, and/or their dependents may not rejoin the SEGIP.

IV. Benefit chart

This section lists Covered Services and the benefits the Plan pays. All benefit payments are based on the Allowed Amount. There is **NO COVERAGE** when services are not authorized by Your PCC except as specifically described in this Summary of Benefits. Coverage is subject to all other terms and conditions of this Plan and must be Medically Necessary.

	Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
A.	**Office visit Copayment for non-preventative services** (1. With Health Assessment, 2. Without Health Assessment or opting in to health coaching)	$30 (1) $35(2)	$35(1) $40 (2)	$65(1) $70 (2)	$85 (1) $90 (2)
B.	**Emergency room Copayment**	$100	$100	$100	25% Coinsurance
C.	**Annual Deductible**	Single: $250 Family: $500	Single: $400Family: $800	Single: $750 Family: $1500	Single: $1500 Family: $3000
D.	**Coinsurance after annual Deductible for services not subject to Copayment**	5%	5%	20%	25%
E.	**Coinsurance for Durable Medical Equipment**	20%	20%	20%	25% Annual Deductible applies
F.	**Prescription Drug Out-of-Pocket Maximum per year**	Single: $1050 Family: $2100	Single: $1050Family: $2100	Single: $1050 Family: $2100	Single: $1050Family: $2100
G.	**Out-of-Pocket Maximum for services other than Prescription Drugs per year**	Single: $1700Family: $3400	Single: $1700Family: $3400	Single: $2400Family: $4800	Single: $3600Family: $7200
H.	**Lifetime Maximum**	Unlimited	Unlimited	Unlimited	Unlimited

NOTES:

- The level of office visit Copayment for You and Your dependents is based on whether You have taken the Health Assessment during each Open Enrollment and received and accepted a call from a health coach. Employees hired after Open Enrollment will be entitled to the lower Copayment. See Section VII for additional information about the Health Assessment.
- The Prescription Drug Out-of-Pocket Maximum and the Out-of-Pocket Maximum for Other Services are per year maximums, and apply across all cost levels.
- All services, except preventive care, Prescription Drugs, hospice, in-network Convenience Clinics and on-line care, maternity are subject to an annual Deductibles.
- See specific benefit description for applicable Copayments, Deductibles, and Coinsurance.
- More than one Copayment or Coinsurance charge may be required if You receive more than one service or see more than one Provider per visit.
- The Prescription Drug Out-of-Pocket Maximum does not include drugs used during inpatient Admission, or drugs for the Treatment of infertility, growth hormones or PKU. It includes Copays and certain Prescription Drug Coinsurance.
- Price difference between brand name and generic drugs may be Your responsibility in certain instances. It is not credited toward the Prescription Drug Out-of-Pocket Maximum.
- Out-of-pocket expenses (including diabetic supplies) obtained using the pharmacy member ID will be credited toward the pharmacy Out-of-Pocket Maximum only and out-of-pocket expenses (including diabetic supplies) obtained using the health plan member ID will be credited toward the health plan member ID only.

- The highest cost level in which any family member incurs expenses determines the amount of the family annual Out of Pocket maximum.
- The highest cost level in which any family Member incurs expenses determines the amount of the family annual Deductibles at the time of service.
- The family Deductible is the maximum amount that a family has to pay in Deductible expenses in any one Calendar year. The family Deductible is not the amount of expenses a family must incur before any family Member can receive benefits. Individual family Members only need to satisfy their individual Deductibles once to be eligible for benefits. Once the family Deductible has been met, Deductibles expenses for the family are waived for the balance of the year.
- For the situation where two state employees are married to each other and one spouse carries single coverage and the other carries family coverage under the same Claims Administrator: this family will have a combined limit of one family Out-of-Pocket Maximum for medical expenses and one family Out-of-Pocket Maximum for pharmacy expenses and one family annual Deductible. It is the responsibility of the employee to notify the Claims Administrator that the combined maximums and Deductibles have been reached within 60 days of the end of the Plan year in which the expenses were incurred.

I. Ambulance

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Ground ambulance to the nearest facility qualified to treat the Illness	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Air ambulance from the place of departure to the nearest facility qualified to treat the Illness	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Medically Necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance

NOTES:

- Air ambulance paid to ground ambulance coverage limit only, unless ordered “first response” or if air ambulance is the only medically acceptable means of transport as certified by the attending physician.
- Except for Medically Necessary, pre-arranged transfers between facilities requested by a physician, coverage is limited to transportation during a Medical Emergency.

NOT COVERED:

- Charges for transportation services other than local ambulance covered under the Plan, except as specified above.
- Please refer to the Exclusions Section.

J. Chemical Health Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Medically Necessary outpatient professional services for diagnosis and Treatment of Substance-Related Disorders rendered in an office.	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90Copay per visit
Medically Necessary outpatient professional services for diagnosis and Substance-Related Disorders rendered on an outpatient basis in a Hospital.	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Medically Necessary inpatient and professional services for Substance-Related Disorders which required the level of care provided only in an acute care facility.	Annual Deductible applies. $100 Copay per Admission	Annual Deductible applies. $200 Copay per Admission	Annual Deductible applies. $500 Copay per Admission	Annual Deductible applies. 25% Coinsurance
Physician and other Professional Medical Services Provided while in the Hospital	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance

NOTES:

- A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a participating chemical health professional concerning the appropriate Treatment site and the extent of services required.
- Care must be arranged through participating chemical dependency Providers. In some cases, referrals to Nonparticipating Providers may be arranged on an exception basis with the prior consent of the Claims Administrator, where the Claims Administrator has determined there are access concerns or special circumstances. For chemical dependency services or Treatment, the Allowed Amount for Nonparticipating Providers is either at the amount agreed between the Claims Administrator and the Provider, or if no such agreement, the lesser of the Provider's billed charges or the prevailing payment amount for the Treatment or services in the area where the services are performed. You pay all charges that exceed the Allowed Amount when You use a Nonparticipating Provider, unless access to a Nonparticipating Provider is necessary due to access or special circumstances as determined by the Claims Administrator.
- Court-ordered Treatment for Chemical Dependency care that is based on an evaluation and recommendation for such Treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified chemical dependency assessor is deemed Medically Necessary without further review by the Claims Administrator. An initial court-ordered exam for a dependent child under the age of 18 is also considered Medically Necessary without further review by the Claims Administrator.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota Statutes, are considered Medically Necessary for the entire Admission.
- For lab and x-ray services billed by a professional, please refer to Physician Services. For lab and x-ray billed by a facility, please refer to Hospital Inpatient or Hospital Outpatient.
- The Plan provides coverage for chemical dependency Treatment provided to a Member by the Department of Corrections while the Member is committed to a state correctional facility following a conviction for a first-degree driving while impaired offense (in accordance with Minn. Stat. Sec. 62Q.137).
- If your Primary Care Clinic or Claims Administrator determines that structured chemical dependency treatment is not medically necessary, you are entitled to a second opinion, paid by the Plan, by a health care professional who is qualified in the diagnosis and treatment of the problem and who is not affiliated with your Claims Administrator

NOT COVERED:

- Custodial and supportive care
- Court-ordered services that do not meet the requirements listed in the "NOTES" section above.
- Charges for services to hold or confine a person under chemical influence when no medical services are required.
- Please refer to the Exclusions Section.

K. Chiropractic Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Chiropractic care rendered to diagnose and treat acute neuromuscular-skeletal conditions	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90Copay per visit

NOTES:

- Members must use a chiropractic Provider within the network of the Claims Administrator You have chosen.
- The chiropractor must notify You when services are not approved and will not be covered.
- For Blue Cross Members, acupuncture is covered only with a referral from the Primary Care Clinic, and with prior approval from Blue Cross.

NOT COVERED:

- Please refer to the Exclusions Section.
- There is no coverage for Maintenance care (care where no measurable or sustainable improvement is expected to be made in a reasonable period of time).
- Massage therapy billed separately.

L. In-network Convenience Clinics and Online Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Care received at convenience clinics/retail health clinics	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply
Online and Virtual Care	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply	$0 Copayment. Annual Deductible does not apply

NOTES:

- Members must use a convenience clinic/retail health clinic within the network and service area of the Claims Administrator You have chosen.
- Members must use an online or virtual care provider within the network of the Claims Administrator You have chosen.
-
- Convenience clinics are staffed by nurse practitioners and physician assistants who are qualified to evaluate, diagnose and prescribe medications (when clinically appropriate) for simple Illnesses, and to provide certain

types of vaccinations and screenings. Services are available to Advantage Health Plan participants at $0 per visit. The first dollar Deductibles are also waived. No appointments are necessary. Individuals with Illnesses outside the scope of services or who exhibit signs of a chronic condition will be referred to their physician or, if critical, the nearest urgent care center or emergency room.

M. Dental Care

The Plan covers:

- Treatment performed within twelve (12) months of accidental injury to repair or replace sound, natural teeth (not including injury caused by biting or chewing) unless the service is an excluded service. Treatment must begin within 12 months of such an injury, or within 12 months of the effective date of coverage under this Plan and be completed within 24 months (assuming coverage is still in effect).
- Medically Necessary surgical or nonsurgical Treatment of temporomandibular joint disorder (TMD) and craniomandibular disorders (CMD).
- Medically Necessary outpatient dental services. Coverage is limited to dental services required for Treatment of an underlying medical condition, e.g., removal of teeth due to complete radiation Treatment for cancer of jaw, cysts, and lesions.
- Cleft lip and cleft palate for any dependent child, including orthodontic Treatment and oral surgery directly related to the cleft.
- Anesthesia, inpatient and outpatient Hospital charges for dental care provided to a covered person who is a child under age five (5), is severely disabled, or has a medical condition that requires Hospitalization or general anesthesia for dental Treatment.
- Oral surgery. Coverage is limited to Treatment of medical conditions requiring oral surgery, such as Treatment of oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws.

Payment is made for the benefits listed above according to the following schedule:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Emergency dental care (See Section IV.N. Emergency and Urgent Care)				
Outpatient Hospital dental services	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Outpatient surgical services rendered	Annual Deductible applies. $60 Copay	Annual Deductible applies. $120 Copay	Annual Deductible applies. $250 Copay	Annual Deductible applies. 25% Coinsurance
Inpatient Hospital dental services	Annual Deductible applies. $100 Copay	Annual Deductible applies. $200 Copay	Annual Deductible applies. $500 Copay	Annual Deductible applies. 25% Coinsurance
Care rendered in an office setting	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit

NOTES:

- Prior authorization is required except for emergency services.

- For cleft lip and cleft palate, if a dependent child is also covered under a dental Plan which includes orthodontic services, that dental Plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same Copayment, conditions and limitations as Durable Medical Equipment.
- Treatment must occur while You are covered under this Plan.
- Orthognathic dental procedures for dependent children under age 18 may be covered under certain circumstances. Please contact Your Claims Administrator. For Members age 18 and over, orthognathic surgery is covered under the reconstructive surgery benefit as long as it is Medically Necessary.

NOT COVERED:

- Dental services to treat an injury from biting or chewing.
- Dental implants and prostheses, including any related Hospital charges.
- Ostiotomies and other procedures associated with the fitting of dentures or dental implants.
- Orthodontia, except when related to the Treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, and for the Treatment of cleft lip and palate for eligible dependent children.
- Oral surgery and anesthesia for removal of impacted teeth and removal of a tooth root without removal of the whole tooth.
- Root canal therapy.
- Tooth extractions, unless otherwise specified as covered.
- Accident-related dental services performed more than twenty-four (24) months after the date of the injury.
- Any other dental procedure or Treatment.
- Dental implants and any associated services and/or charges, except when related to services for cleft lip and palate that are scheduled or initiated prior to a Member turning age 19, or for eligible dependent children.
- Please refer to the Exclusions Section.

N. Emergency and Urgent Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Emergency care/urgent care in a physician's office or an urgent care center.	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Emergency care/urgent care in a Hospital emergency room.	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. 25% Coinsurance
Emergency dental care in an out-patient Hospital or emergency room.	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. 25% Coinsurance
Enhanced radiology services Annual Deductible applies.	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 15% Coinsurance	Annual Deductible applies. 25% Coinsurance	Annual Deductible applies. 30% Coinsurance

NOTES:

Be prepared for the possibility of an emergency before the need arises, by knowing Your Primary Care Clinic procedures for care needed after regular clinic hours. Determine the telephone number to call, the Hospital Your

PCC uses, and other information that will help You act quickly and correctly. Keep this information in an accessible location in case an emergency arises.

If the situation is life-threatening call 911.

If the situation is an emergency, You should go to the nearest facility. A Medical Emergency is Medically Necessary care of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which a reasonable layperson believes to be immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or part, or prevent placing the physical or mental health of the patient in serious jeopardy.

If the situation is not an emergency, please call Your PCC before receiving care. Each PCC has someone on call 24 hours a day, seven days a week. When You call You will be directed to the appropriate place of Treatment for Your situation.

If You are admitted to a facility for an Emergency service please notify Your Primary Care Clinic as soon as possible so that it can coordinate all subsequent care. Your Primary Care Clinic may decide to transfer You to its designated Hospital. In that case, the Plan will provide coverage for the ambulance used for the transfer, according to the ambulance benefit listed in Section IV.I.

Emergency room services are subject to the Copays listed in the Benefit Schedule unless You are admitted within 24 hours for the same condition. Follow-up care for emergency services (e.g., suture removal, cast changes) is not an emergency service and must be provided or authorized by Your PCC to receive Your best benefit.

Urgent Care

Urgent care problems include injuries or Illnesses such as sprains, high fever or severe vomiting which are painful and severe enough to require urgent Treatment but are not life-threatening. You may seek assistance at any urgent care without contacting Your own Primary Care Clinic.

All Members may receive urgent care while away from home, but for routine care received away from home, please see Section V.A, Authorized Care Outside the Service Area.

O. Habilitative and Rehabilitative Therapy Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Rehabilitative or habilitative physical, speech and occupational therapy services received in a clinic, office or as an outpatient	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Massage therapy that is performed in conjunction with other Treatment/ modalities by a physical or occupational therapist and is part of a prescribed Treatment Plan and is not billed separately	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $350/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit

NOTES:

- Physical, occupational, and speech therapy services are covered if the habilitative care is rendered for congenital, developmental, or medical conditions which have limited the successful initiation of normal speech and motor development. Benefits may be supplemented and coordinated with similar benefits made available by other agencies, including the public-school system. To be considered habilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Member's maximum potential ability.

- Rehabilitative therapy is covered to restore function after an Illness or injury, provided for the purpose of obtaining significant functional improvement within a predictable period of time, toward a Member's maximum potential to perform functional daily living activities.
- For rehabilitative care rendered in the Member's home, please see Section IV.P, Home Health Care.

NOT COVERED:

- Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club Memberships, and/or any related diagnostic testing.
- Charges for maintenance or custodial therapy; charges for rehabilitation or habilitative services that are not expected to make measurable or sustainable improvement within a reasonable period of time.
- Please refer to the Exclusions Section.
- There is no coverage for services not authorized by Your Primary Care Clinic.

P. Home Health Care

The Plan covers Medically Necessary rehabilitative, habilitative or terminal:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Care ordered in writing by a physician	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 20% coinsurance	Annual deductible applies. 25% coinsurance
Care provided by a Medicare certified Home Health Agency	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 20% coinsurance	Annual deductible applies. 25% coinsurance
Skilled Care must be provided by the following Home Health Agency employees: • registered nurse • licensed practical nurse • licensed registered physical therapist • registered occupational therapist • certified speech and language pathologist • respiratory therapist • medical technologist • registered dietician	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 20% coinsurance	Annual deductible applies. 25% coinsurance
Services of a home health aide or social worker employed by the Home Health Agency when provided in conjunction with services provided by the above listed agency employees	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 20% coinsurance	Annual deductible applies. 25% coinsurance
Home Health Care following early Maternity Discharge, Section IV.T. or IV.V.	Nothing	Nothing	Nothing	Nothing

NOTES:

- Benefits for Prescription Drugs used during home health care are listed under Prescription Drugs, Section IV.AA.

- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy, Section IV.R.
- Person must be homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status.

NOT COVERED:

- Charges for services received from a personal care attendant.
- Occupational and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time
- Services provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home.
- Please refer to the Exclusions Section.
- There is no coverage for services not authorized by Your PCC.

Q. Palliative Care

The Plan covers Medically Necessary palliative care as follows:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Care ordered in writing by a physician and included in the written home care plan	Nothing	Nothing	Nothing	Nothing
Professional visits by registered nurses (RNs), social workers (SWs), and chaplains to assist with advance care planning and/or accompany patient to office visits. (Note: RNs and SWs may not provide transportation for the patient.)	Nothing	Nothing	Nothing	Nothing
Advance Practice Registered Nurse services to evaluate and modify the plan of care, only when such services are not covered under another benefit under the Plan	Nothing	Nothing	Nothing	Nothing
Pediatric and/or adolescent anticipatory grief support counseling services	Nothing	Nothing	Nothing	Nothing
Home health aide and respite care services	Nothing	Nothing	Nothing	Nothing
Bereavement program services, including: calls, mailings, visits, and support groups	Nothing	Nothing	Nothing	Nothing

NOT COVERED:

- Please refer to the Exclusions Section.
- Services provided by your family or a person who shares your legal residence.
- Respite or rest care except as specifically described in this section.
- Companion and home care services, unskilled nursing services.
- Services provided as a substitute for a primary care giver in the home.
- Services that can be performed by a non-medical person or self-administered.
- Home health aides, in lieu of nursing services.
- Services provided in the patient's home for convenience or due to lack of transportation.
- Custodial care.

R. Home Infusion Therapy

The Plan covers Medically Necessary

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Home infusion therapy services when ordered by a physician and provided by a participating Medicare certified home infusion therapy Provider associated with Your PCC	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Solutions and pharmaceutical additives, pharmacy compounding and dispensing services	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Durable medical equipment	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Ancillary medical supplies	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Nursing services to: • train You or Your caregiver, or • monitor the home infusion therapy	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Other eligible home health services and supplies provided during the course of home infusion therapy	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance

NOT COVERED:

- Charges for nursing services to administer therapy when the patient or another caregiver can be successfully trained to administer therapy.
- Services that do not involve direct patient contact, such as delivery charges and recordkeeping.
- Please refer to the Exclusions Section.
- There is no coverage for services not authorized by Your PCC.

S. Hospice Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Hospice care for the Terminally Ill Patients provided by a Medicare-certified Hospice Provider or other preapproved hospice.	Nothing	Nothing	Nothing	Nothing
Inpatient and outpatient Hospice Care and other supportive services provided to meet the physical, psychological, spiritual, and social needs of the dying individual	Nothing	Nothing	Nothing	Nothing
Prescription drugs, in-home lab services, IV therapy, and other supplies related to the terminal Illness or injury prescribed by the attending physician or any physician who is part of the Hospice Care team	Nothing	Nothing	Nothing	Nothing
Instructions for the care of the dying patient, bereavement counseling, Respite Care and other supportive services for the family of the dying individual, both before and after the death of the individual	Nothing	Nothing	Nothing	Nothing

NOTES:

- This is a special way of providing services to people who are terminally ill, and their families. Hospice care is physical care, including pain relief and symptom management, and counseling that is provided by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be provided in the home, in a hospice facility, a Hospital or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by providing comfort and relief from pain. The focus is on care, not cure.
- The patient's Primary Care Provider must certify in writing an anticipated life expectancy of six (6) months or less.
- The patient and family must agree to the principles of Hospice Care.
- Coverage will be provided for two (2) episodes of Hospice Care, per person, per lifetime for the same terminal Illness or injury. You may utilize hospice benefits and go back to standard Plan benefits, but may go back, again, to hospice benefits only once per lifetime for the same Illness or condition.
- An episode of Hospice Care is defined as the period of time beginning on the date a Hospice Care program is established for a dying individual, and ending on the earliest of:
  - six (6) months after the establishment of the program (subject to review by the Claims Administrator);
  - the date the attending physician withdraws approval of the hospice program;
  - the date the individual declines the hospice benefit and waiver; or
  - the date of the individual's death.
- Two (2) or more episodes of Hospice Care will be considered one (1) episode unless separated by a period of at least three (3) months during which no hospice program is in effect for the individual.
- Coverage for Respite Care is limited to not more than five (5) consecutive days at a time up to a maximum total of 30 days during the episode of Hospice Care, combined with days of continuous care.
- Services provided by the primary care physician are covered but are separate from the hospice benefit.
- The patient must agree to waive the standard benefits under the Plan, except when Medically Necessary because of an Illness or injury unrelated to the terminal diagnosis.
- You pay all charges when You use a Provider without referral from Your PCC.
- You may withdraw from Hospice Care at any time.

NOT COVERED:

- Financial or legal counseling services.
- Room and board expenses in a residential hospice facility or a skilled nursing facility.
- Please refer to the Exclusions Section.

T. Inpatient Hospital

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
365 (366) days per Calendar Year for Semiprivate Room and board and general nursing care. Private room is covered only when Medically Necessary	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Intensive care and other special care units	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Operating, recovery, and Treatment rooms	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Anesthesia	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Prescription Drugs and supplies used during a covered Hospital Admission	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Lab and diagnostic imaging	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Enhanced radiology services, including CT scans and MRIs	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Physical, occupational, radiation and speech therapy	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Anesthesia, inpatient Hospital charges for dental care provided to a covered person who is a child under age five (5), is severely disabled, or has a medical condition that requires Hospitalization or general anesthesia for dental Treatment	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
General nursing care	Annual Deductible applies. $100 Copay per inpatient Admission	Annual Deductible applies. $200 Copay per inpatient Admission	Annual Deductible applies. $500 Copay per inpatient Admission	Annual Deductible applies. 25% Coinsurance
Physician and other professional medical services provided while in the Hospital	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance
Emergency care **(See Section IV.N. Emergency and Urgent Care.)**				

NOTES:

- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.
- Inpatient Copayments are waived if You are readmitted to the Hospital within 48 hours for Treatment of the same condition.
- The inpatient Copayment is waived for bariatric surgery if the procedure is performed at a designated Center of Excellence.
- The deductible and copayment are waived for the newborn nursery charge. A "newborn admission" means the admission date is equal to the baby's date of birth
- Includes gender reassignment surgery that meets medical criteria

NOT COVERED:

- Please refer to the Exclusions Section.

U. Organ and Bone Marrow Transplant Coverage

Benefit Feature	If service are authorized by Your PCC and obtained from a Transplant Center designated by Your Claims Administrator	If services are not authorized by Your PCC
Services, supplies, drugs and related aftercare for the following human solid organ and blood and marrow transplant procedures, including umbilical cord blood and peripheral blood stem cell support procedures: Allogeneic and syngeneic bone marrow for: • Acute leukemia and chronic myelogenous leukemia • Myelodysplasia • Aplastic anemia • Wiskott-Aldrich syndrome • Cartilage-hair hypoplasia • Kostmann's syndrome • Infantile osteopetrosis • Neuroblastoma • Primary granulocyte dysfunction syndrome • Thalassemia major • Chronic granulomatous disease • Severe mucupolysaccharidosis • Hodgkin's and non-Hodgkin's lymphoma	See Benefit Chart on Page 42	No coverage

Benefit Feature	If service are authorized by Your PCC and obtained from a Transplant Center designated by Your Claims Administrator	If services are not authorized by Your PCC
Severe combined immunodeficiency disease • Mucolipidosis • Myelodysplastic syndrome • Sickle cell disease • Multiple myeloma • Ewing's sarcoma • Medulloblastoma-peripheral neuroepithelioma		
Autologous bone marrow and autologous peripheral stem cell support for: • Acute lymphocytic or non-lymphocytic leukemia • Chronic myelogenous leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma • Testicular, mediastinal, retroperitoneal, ovarian germ cell tumors • Multiple myeloma • Ewing's sarcoma, and medulloblastoma-peripheral neuroepithelioma		
Heart		
Liver (cadaver and living)		
Lung (single or double)		
Pancreas transplant for: a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session.		
Air or ground transportation expenses incurred by the courier service to procure bone marrow that is later transplanted into You at a participating Transplant Center during one of the Covered Services listed above.		

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
If care is received:				
In an office setting	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
In an outpatient Hospital or surgical facility	Annual Deductible applies. $60 Copay per visit	Annual Deductible applies. $120 Copay per visit	Annual Deductible applies. $250 Copay per visit	Annual Deductible applies. 25% Coinsurance
In an inpatient Hospital setting. (Copayment waived for Treatment received at Center of Excellence facility.)	Annual Deductible applies. $100 Copay per visit.	Annual Deductible applies. $200 Copay per visit	Annual Deductible applies. $500 Copay per visit	Annual Deductible applies. 25% Coinsurance.

NOTES:

- Transplant services must be performed at a center of excellence for transplants or participating transplant Provider designated by Your Claims Administrator. The transplant-related Treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this Summary of Benefits.
- Medical and Hospital expenses of the donor are covered only when the recipient is a covered person and the transplant has been approved for coverage. Treatment of medical complications that may occur to the donor are not covered.
- Transplant coverage is subject to the medical policy of the Claims Administrator.
- As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions.
- Pre-certification, prior notification for currently approved procedures, or Prior Authorization may be required, depending upon the procedures designated by Your Claims Administrator.
- The Plan covers eligible transplant services that are not experimental, investigational or unproven procedures, and are without contraindications, while You are a Member. Coverage for organ transplants, bone marrow transplants and bone marrow rescue services is subject to periodic review and modification when new medical/scientific evidence and/or technology supports a finding that a procedure is no longer an Investigative procedure, or if medical/scientific evidence supports a finding that a procedure is no longer the standard/acceptable Treatment for a specific condition.
- Transplant travel benefit:

  If You live more than 50 miles from a transplant Provider designated as a Center of Excellence (or, for Blue Cross Members, a Blue Distinction Centers for Transplant Provider), travel reimbursement may be available under the Plan, as follows:

  - Available when You travel more than 50 miles to obtain transplant care.
  - Available only when coverage under the Advantage Plan is primary.
  - Covers the patient up to $50 per day for lodging.
  - Covers a companion/caregiver up to $50 per day for lodging.
  - Covers the lesser of (1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or (2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the Provider only.
  - Total reimbursement shall not exceed $5,000 per lifetime. Deductible applies
  - Lodging is eligible when staying at rental properties, such as apartments, hotels, motels, or Hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
  - Reimbursed expenses are not tax Deductibles.

Exclusions:

- Travel benefits are not covered when You are using a Provider not designated by a Center of Excellence (or, for Blue Cross Members, a Blue Distinction Centers for Transplant Provider);
- Non-covered travel expenses include but are not limited to utilities, child care, pet care, security deposits, cable hook-up, dry cleaning and laundry, car rental, and personal items.
- Lodging is not covered when staying with family or friends.
- Travel benefits are not covered if Advantage coverage is secondary.
- The travel benefit does not cover meals.
- The travel benefit does not apply to kidney and cornea transplants which are covered under the Physician Services and Inpatient Hospital benefits.

NOT COVERED:

- 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 of Benefits.
- Transplantation of animal organs and/or tissue.
- Additional exclusions are listed in the Exclusions Section.

V. Maternity

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Professional services for prenatal care and postnatal care	Nothing	Nothing	Nothing	Nothing
Professional services for delivery	Nothing	Nothing	Nothing	Nothing

NOTES:

- Female employees and/or covered female dependents may obtain direct access without a referral or any other Prior Authorization from their Primary Care Clinic (PCC) or any other person to an obstetrical or gynecological health care professional in the network of Your chosen Claims Administrator who specializes in obstetrics or gynecology for the following services: annual preventive health examinations and any Medically Necessary follow-up visits, maternity care, evaluation and necessary Treatment for acute gynecologic conditions or emergencies. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved Treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Your chosen health Claims Administrator.
- Under Federal law, group health Plans such as this Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn child's attending Provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable).
- Under Federal law, the Plan may not require that a Provider obtain authorization from the Plan for prescribing a length of stay less than the 48 hours (or 96 hours) mentioned above.

- The Plan covers one (1) home health 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. Refer to Home Health Care, section IV.P.
- You pay all charges when You use a Provider not in the OB/GYN Network.
- Maternity care may be provided to members in hospitals in either network of the Primary Care Clinic or the OB/GYN clinic.
- The Plan covers aspirin: Pregnant Women at high risk for preeclampsia
- The Plan covers breastfeeding interventions

NOT COVERED:

- Please refer to the Exclusions Section.

W. Mental Health

The Plan covers:

- Outpatient health care professional services for diagnosis and Treatment of behavioral health disorders, evaluation, and crisis intervention.
- Outpatient Hospital/outpatient behavioral health facility charges.
- Inpatient health care professional charges.
- Inpatient Hospital/residential behavioral health facility charges.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
If care is received:				
• In an office setting	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
• In an outpatient Hospital or surgical facility	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
• In an inpatient Hospital setting	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $200 Copay per visit	Annual Deductible applies. $500 Copay per visit	Annual Deductible applies. 25% Coinsurance
• Physician and other professional medical services provided while in the Hospital	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance
• In a licensed residential Hospital setting	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $200 Copay per visit	Annual Deductible applies. $500 Copay per visit	Annual Deductible applies. 25% Coinsurance

NOTES:

- Members must use a Network Provider.
- Court-ordered Treatment for Mental Health care that is based on an evaluation and recommendation for such Treatment or services by a physician or licensed psychologist is deemed Medically Necessary without further review by the Claims Administrator. An initial court-ordered exam for a dependent child under the age of 18 is also considered Medically Necessary without further review by the Claims Administrator.

- All mental health Treatment must be provided by a licensed mental health professional operating within the scope of his or her license.
- Outpatient family therapy is covered if part of a recommended Treatment Plan, for a mental health diagnosis.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders. (For physical, occupational and speech therapy services for autism, see Section IV.O. Registered dietician service for eating disorders are covered at the same level as any other mental health services.)
- Treatment of emotionally disabled children in a licensed residential Treatment facility is covered the same as any other inpatient Hospital medical Admission.
- Care must be arranged through participating Providers. In some cases, referrals to non-participating Providers may be arranged on an exception basis with the prior consent of the Claims Administrator, where the Claims Administrator has determined there are access concerns or special circumstances. For mental health services or Treatment, the Allowed Amount for Nonparticipating Providers is either at the Provider's billed charges or the prevailing payment amount for the Treatment or services in the area where services are performed. You pay all charges that exceed the Allowed Amount when You use a Nonparticipating Provider, unless access to a Nonparticipating Provider is necessary due to access or special circumstances as determined by the Claims Administrator.
- If your Primary Care Clinic or Claims Administrator determines that structured mental health treatment is not medically necessary, you are entitled to a second opinion, paid by the Plan, by a health care professional who is qualified in the diagnosis and treatment of the problem and who is not affiliated with your Claims Administrator.
- Benefits are provided for autism treatment, including intensive behavioral therapy programs for the treatment of autism spectrum disorders including but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.
- Treatment for gender dysphoria and gender reassignment if medically necessary based on the most recent, published standards of nationally recognized medical experts in the transgender field. Please consult your plan's coverage criteria for more information.
- Treatment related to Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) treatment.

NOT COVERED:

- Services for mental health not listed in the most recent edition of DSM-5
- Custodial and supportive care
- Court-ordered services that do not meet the requirements listed in the Notes section above.
- Please refer to the Exclusions Section
- Charges for services that are provided without charge, including services of the clergy that are normally provided without charge
- Charges for marital, relationship, training services and religious counseling
- Sex therapy in the absence of a diagnosed mental disorder

X. Outpatient Hospital Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
General nursing care	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Physician and other professional and medical services	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Drugs administered during therapy	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Radiation and chemotherapy	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Kidney dialysis	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Outpatient Hospital charges for dental care provided to a covered person who is a child under age five (5), is severely disabled or has a medical condition that requires Hospitalization or general anesthesia for dental Treatment	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Enhanced radiology services, including but not limited to CT scans, magnetic resonance imaging (MRI) and nuclear imaging	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 15% Coinsurance	Annual Deductible applies. 25% Coinsurance	Annual Deductible applies. 30% Coinsurance
Other diagnostic or Treatment-related outpatient services	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Diabetes self-management and education including medical nutrition therapy	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Scheduled surgery and all related services and supplies in an outpatient Hospital or surgical facility	Annual Deductible applies. $60 Copay	Annual Deductible applies. $120 Copay	Annual Deductible applies. $250 Copay	Annual Deductible applies. 25% Coinsurance
Dental surgery provided to a covered person who is a child under age five (5), is severely disabled or has a medical condition that requires Hospitalization or general anesthesia for dental Treatment	Annual Deductible applies. $60 Copay	Annual Deductible applies. $120 Copay	Annual Deductible applies. $250 Copay	Annual Deductible applies. 25% Coinsurance
Lab and diagnostic imaging	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Physical, occupational and speech therapy	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Emergency care (See Section IV.N. Emergency and Urgent Care)				

NOTES:

- Refer to Sections III.A.1.g. or IV.N. for a complete description of Your responsibilities in an emergency.
- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.
- Includes gender reassignment surgery that meets medical criteria.

NOT COVERED:

- Please refer to the Exclusions Section.

Y. Phenylketonuria (PKU)

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Special dietary Treatment for phenylketonuria (PKU) when recommended by a physician	20% Coinsurance, not subject to annual Deductibles	20% Coinsurance, not subject to annual Deductibles	20% Coinsurance, not subject to annual Deductibles	25% Coinsurance, not subject to annual Deductibles

NOTES:

- Applies to the medical Out-of-Pocket Maximum, but not to the Prescription Drug Out-of-Pocket Maximum.

NOT COVERED:

- Please refer to the Exclusions Section.

Z. Physician Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Office visits for Illness or injury, including Telemedicine	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Surgery or surgical services received during an office visit, including circumcision and sterilization	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Hearing aid exams, audiometric tests and Audiologist Evaluations which are provided by a participating Audiologist or Otolaryngologist. A referral from Your PCC is not necessary	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Testing, diagnosis and Treatment of infertility up to the diagnosis of infertility but not including any form of artificial insemination or assisted reproductive technologies	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Allergy testing	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
Diabetes outpatient self-management training and education, including medical nutrition therapy	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90Copay per visit
Physician services related to a covered inpatient Hospital Admission	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance
Physician services related to an emergency room visit	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Physician services related to an outpatient surgery in a Hospital or surgical facility	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance
Anesthesia by a Provider other than the operating, delivering, or assisting Provider	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance
Lab (including allergy shots), Pathology, X-ray, Radiation and Chemotherapy, and any other services not included as part of preventive care and not subject to office visit or facility Copayments	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Physician services related to an outpatient Hospital service	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 5% Coinsurance	Annual Deductible applies. 20% Coinsurance	Annual Deductible applies. 25% Coinsurance
Enhanced radiology services, including but not limited to CT scans, magnetic resonance imaging (MRI), and nuclear imaging.	Annual Deductible applies. 10% Coinsurance	Annual Deductible applies. 15% Coinsurance	Annual Deductible applies. 25% Coinsurance	Annual Deductible applies. 30% Coinsurance

NOTES:

- Female employees and/or covered female dependents may obtain direct access without a referral or any other Prior Authorization from their Primary Care Clinic (PCC) or any other person to an obstetrical or gynecological health care professional in the network of Your chosen Claims Administrator who specializes in obstetrics or gynecology for the following services: annual preventive health examinations and any Medically Necessary follow-up visits, maternity care, evaluation and necessary Treatment for acute gynecologic conditions or emergencies. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved Treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Your chosen Claims Administrator.
- The Plan covers surgery and pre- and post-operative care for an Illness or injury. The Plan does not cover a charge separate from the surgery for pre- and post-operative care. If more than one (1) surgical procedure is performed during the same operative session, the Plan covers them based on the Allowed Amount for each procedure.
- Charges for physician services related to Major Organ and Bone Marrow Transplant Expense Coverage are included in the Transplant Payment Allowance.
- Treatment of diagnosed Lyme disease is covered on the same basis as any other illness.
- Refer to the Supplies and Durable Medical Equipment Section for Hearing Aid evaluation tests and Hearing Aid benefits.
- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.

NOT COVERED:

- Charges for reversal of sterilization
- Charges for any form of assisted reproductive technologies (ART) which includes in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)1 (refer to footnote 1)
- Charges for sperm banking, charges for donor ova or sperm charges for drug therapies related to infertility
- Separate charges for pre- and post-operative care
- Please refer to the Exclusions Section.

AA. Prescription Drugs and Services

Prescription drugs and services are administered by the Advantage Plan's pharmacy benefit manager, CVS Caremark. Members will receive a separate Membership card and Member handbook from CVS Caremark.

Members pay the following Copayments when purchasing a drug at a network pharmacy:

Formulary Tier 1 drugs	$18 Copayment for each 30-day supply
Formulary Tier 2 drugs	$30 Copayment for each 30-day supply
Formulary Tier 3 drugs	$55 Copayment for each 30-day supply

Certain Prescription Drugs may be purchased through a retail CVS Pharmacy or the CVS Caremark Mail Order Pharmacy for two Copayments for a three-month supply.

NOTES:

- The following prescriptions qualify for the Copayment terms above:
    - A 30-day supply from an in-network Retail Pharmacy, (including CVS pharmacies located inside Target Stores)
    - Up to a 90-day supply from an in-network Retail Pharmacy (including CVS pharmacies located inside Target Stores) or from CVS Caremark Mail Service
    -
- The Formulary is a comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists. The Formulary serves as a guide for the Provider community by identifying which drugs are preferred. It is updated regularly and includes preferred brand name and generic drugs. The Formulary is available at the CVS Caremark Web site, www.caremark.com.
- Medications are covered up to a 30-day supply of medication per Copayment, unless otherwise specified.
- Certain drugs require Prior Authorization in order for coverage to apply.
- Certain drugs have quantity limits.
- Diabetic supplies (including test strips, lancets, and syringes) are covered with a 20 percent Coinsurance (25 percent in cost level 4).
- Certain Specialty Medications are required to be dispensed through CVS Caremark Specialty Pharmacy.
- All other provisions in this document apply to the Prescription Drug benefit.
- Non-Formulary brand name drugs are not covered unless CVS Caremark has approved a Formulary exception submitted by Your physician.
- If You choose a brand name drug when the equivalent generic drug is available, You will also pay the difference in the Allowed Amount between the brand name and the generic drug, in addition to the

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[1] Infertility Coverage offered by HealthPartners includes: certain professional services, services for diagnosis and Treatment of infertility, Medically Necessary tests, facility charges, and laboratory work related to Covered Services. Artificial insemination and/or super-ovulatory drugs for covered persons diagnosed with infertility is limited to six cycles per confirmed pregnancy. Coinsurance amounts for infertility drugs apply to the medical Out-of-Pocket Maximum, but not to the Prescription Drug Out-of-Pocket Maximum. Drugs for the Treatment of infertility are supplied, for HealthPartners Members only, through CVS Caremark.

applicable Copayment. The additional cost difference is not an eligible expense and will not be credited toward Your out-of-pocket pharmacy maximum. When You have reached Your Prescription Drug Out-of-Pocket Maximum, You still pay the difference in the Allowed Amount between the brand name and the generic drug, even though You are no longer responsible for the Prescription Drug Copayments. You may pay significantly more in out-of-pocket costs if You choose a brand name drug when a generic drug is available, up to the cost of the brand name drug. Non-Formulary brand name drugs are not covered unless CVS Caremark has approved a Formulary exception submitted by Your physician.

- Drugs that are not Tier 2 may be eligible to be obtained at a Tier 2 Copay if Your physician submits a Tiering exception that meets the CVS Caremark approval criteria.
- Dispense as written (DAW) does not override the generic requirement unless the Member has appealed for and received a Brand Penalty exception.
- CVS Caremark offers a Formulary exception process for exceptions to the Formulary. See page 51 for information on filing a Formulary exception.
- A formulary exception will be granted when the formulary drug causes an adverse reaction, when the formulary drug is contraindicated, or when the prescriber demonstrates that a prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee.
- Prescription drugs for the Treatment of infertility are covered for HealthPartners Members only with a 20% Coinsurance. The Coinsurance amount applies to the medical Out-of-Pocket Maximum and NOT to the Prescription Drug Out-of-Pocket Maximum.
- All prescriptions must be filled at a participating pharmacy, except when this is not reasonably possible in emergency or urgent situations. In the event You pay the entire cost of the prescription, You may submit a claim form for reimbursement via Caremark.com, the CVSCaremark Mobile Application or by mailing the claims form(Claim forms are located at www.caremark.com or You may call CVS Caremark Customer Care toll free at 1-844-345-3234 for assistance.) In these situations, the reimbursement amount is based on the pharmacy contracted rate and You may be responsible for more than the Copayment amount. In emergency situations, the reimbursement amount will be at the same rate as if you has used a participating pharmacy. A listing of participating pharmacies is available at www.caremark.com.
- The Plan covers drugs for the Treatment of emotional disturbance or mental Illness; the Plan complies with the statute's requirements regarding continuing care and Formulary exceptions.
- Drugs administered during a Hospital stay are covered under the inpatient Hospital benefit.
- Self-administered injectables are covered through Your pharmacy benefit.
- Oral amino-based elemental formulae are covered if they meet the medical necessity criteria of the Claims Administrator
- Pharmacy benefits for preventive over-the-counter products with a prescription, as determined by Health Care Reform and the Patient Protection and Affordable Care Act are provided at no cost.
    - Aspirin: Adults age 50 and over:
    - Aspirin: Pregnant Women at high risk for pre-eclampsia
    - Bowel Preparation Medications: Screening for Colorectal Cancer age 50 and over
    - Folic Acid: Women under age 55
    - Immunizations: Children and Adult
    - Low-Dose Statins: Adults age 40-75
    - Oral fluoride: Children age 5 and under
    - Women's Preventive Services: contraceptives
    - Tobacco Cessation Products: prescription and prescription OTC

SPECIAL NOTE REGARDING PRESCRIPTION DRUGS FOR MENTAL ILLNESS OR EMOTIONAL DISTURBANCE:

- Prescription drugs for non-Formulary antipsychotic drugs prescribed to treat emotional disturbance or mental Illness will be covered at the same level as Formulary drugs if the prescribing health care professional indicates that the prescription must be "Dispense As Written" ("DAW") and certifies in writing to us that he or

she has considered all equivalent drugs in the Formulary and has determined that the drug prescribed will best treat the patient's condition.

- If You are taking a Formulary drug to treat mental Illness or emotional disturbance and the drug is removed from the Formulary, or if You are taking a non-Formulary drug to treat mental Illness or emotional disturbance when You change health Plans and the medication has shown to effectively treat Your condition, the non-Formulary drug will be covered at the same level as a Formulary drug for up to one (1) year if:
  - You have been treated with the drug for 90 days prior to a change in the Formulary or a change in Your health Plan;
  - The prescribing health care professional indicates that the prescription must be "DAW"; and
  - The prescribing health care professional certifies in writing to us that the drug prescribed will best treat Your condition.
- The continuing care provision described above may be extended annually if the prescribing health care professional indicates that the prescription must be "DAW" and certifies in writing to us that the drug prescribed will best treat Your condition.
- If the prescribing health care professional believes that You need coverage for a drug that is used to treat a mental health condition that is not on the Formulary, there is a process to request an exception. The health care professional must submit clinical documentation showing that the Formulary drug(s) cause an adverse reaction or is contraindicated for the patient, or that the non-Formulary drug must be "DAW" to provide maximum benefit to the patient.

NOT COVERED:

- Drugs that the federal government has not approved for sale.
- Charges for over-the-counter drugs that are not preventive as prescribed by a physician: vitamin therapy or Treatment, appetite suppressants.
- Prescription drugs classified as less than effective by the federal government, biotechnological drug therapy which has not received federal approval for the specific use being requested except for off-label use in cancer Treatment as specified by law; Prescription Drugs which are not administered according to generally accepted standards of practice in the medical community.
- Prescription drugs for infertility (except for those covered for HealthPartners Members).
- Replacement of drugs due to loss, damage or theft.
- Bulk Chemicals
- Drugs used for cosmetic Treatments such as Retin-A, Rogaine, or their medical equivalent.
- Unit dose medications, including bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging. Drugs recently approved by the federal government may be excluded until reviewed and approved by the Pharmacy and Therapeutic Committee, which determines the therapeutic advantage of the drug and the medically appropriate application.

How do I make a complaint or file an appeal?

When You have a concern about a benefit, claim or other service, please call Caremark Customer Care toll-free at 1-844-345-3234. Customer Care Representatives will answer Your questions and resolve Your concerns quickly.

Pharmacy appeals

The CVS Caremark Appeals Department carefully reviews all of the information that is provided and applies the terms of Your pharmacy benefit Plan to Your request for review. All information is reviewed on a case by case basis, specific to each Member and the circumstances surrounding the request.

If Your issue or concern is not resolved by calling Customer Care, You have the right to file a written appeal with CVS Caremark. Please send this appeal, along with any related information from Your doctor, to:

Fax

CVS Caremark
1-866-443-1172
ATTN: Appeals Department

Mail

Caremark, Inc.
Appeals Department MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

The appeal must be resolved within 30 days of filing with CVS Caremark

BB. Preventive Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Preventive medical evaluations	Nothing	Nothing	Nothing	Nothing
Routine gynecological exams	Nothing	Nothing	Nothing	Nothing
Routine cancer screening	Nothing	Nothing	Nothing	Nothing
Lab and diagnostic imaging	Nothing	Nothing	Nothing	Nothing
Standard immunizations and vaccinations	Nothing	Nothing	Nothing	Nothing
Routine hearing exams	Nothing	Nothing	Nothing	Nothing
Prenatal and postnatal care	Nothing	Nothing	Nothing	Nothing
Routine eye exams	Nothing	Nothing	Nothing	Nothing
Counseling (individual, group and telephone) for purposes of tobacco cessation	Nothing	Nothing	Nothing	Nothing

NOTES:

- Female employees and/or covered female dependents may obtain direct access without a referral or any other Prior Authorization from their Primary Care Clinic (PCC) or any other person to an obstetrical or gynecological health care professional in the network of Your chosen Claims Administrator who specializes in obstetrics or gynecology for the following services: annual preventive health examinations and any Medically Necessary follow-up visits, maternity care, evaluation and necessary Treatment for acute gynecologic conditions or emergencies. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved Treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Your chosen health Claims Administrator.
- Coverage for an annual preventative mammogram screening using digital breast tomosynthesis (3D), if the enrollee is at risk for breast cancer defined as: Having a family history with one or more first or second-degree relatives with breast cancer; testing positive for BACRA1 or BRACA2 mutations; having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology: or having a previous diagnosis of breast cancer.
- Benefits for routine preventive care for a child under age six (6) are listed under the Well Child Care, Section IV.HH.
- Non-routine eye and hearing exams are subject to referral from Your PCC, and subject to an office Copay.
- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.
- Routine eye exams are covered once per Plan year under the preventive care benefit.

- Remember that during a visit for routine care (such as hearing and eye exams, and annual physical exams), if Your Provider indicates a non-preventive diagnosis code because of additional attention to a specific condition, Your exam may no longer be considered routine and You may be charged a Copay or Deductibles. Should You have questions, please contact Your Claims Administrator.
- Benefits for services identified as preventive care are determined based on recommendations and criteria established by professional associations and experts in the field of preventive care, (i.e. United States Preventive Services Task Force-USPSTF).
- Eligible standard immunizations (e.g. diptheria or tetanus) are covered under the preventive care benefit based on recommendations and criteria established by professional associations and experts in the field of preventive care.
- Statin preventative medication for prevention of cardiovascular disease
- Folic acid supplementation for all women who are planning or capable of pregnancy
- Related to tobacco cessation, the plan covers the following without cost-sharing:
  1. Screening for tobacco use; and,
  2. For those who use tobacco products, two tobacco cessation attempts per year. For this purpose, covering a tobacco cessation attempt includes coverage for:
     - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and
     - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider.
- Aspirin: Adults age 50 and over, when prescribed by a health care provider
- Aspirin: Pregnant women at high risk for preeclampsia, when prescribed by a health care provider
- Breastfeeding intervention
- Tuberculosis screening: adults in populations at increased risk
- Syphilis screening: persons who are at increased risk for infection
- Colorectal cancer screening starting at age 50 years and continuing until age 75, unless determined to be medically necessary by your provider.
- Depression screening for major depressive disorder (MDD): adolescents ages 12 to 18 years
- Depression screening for depression in adult population, including pregnant and postpartum women.
- Routine cancer screening including pap smears, mammograms, and surveillance tests for ovarian cancer for women who are risk for ovarian cancer.
- Prostate cancer screening for men 50 years of age or older and men 40 years of age of over who are symptomatic or in a high-risk category
- BRCA risk assessment and genetic counseling/testing

NOT COVERED:

- Charges for physical exams for the purpose of obtaining employment or insurance, unless otherwise Medically Necessary
- Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club Memberships, tobacco reduction programs (unless Medically Necessary, appropriate Treatment, and a Plan-approved program), and any related diagnostic testing
- Charges for lenses, frames, contact lenses or other fabricated optical devices or professional services for the fitting and/or supply thereof (except when eligible under the Supplies and Durable Medical Equipment Section), including the Treatment of refractive errors such as radial keratotomy
- Please refer to the Exclusions Section.

CC. Reconstructive Surgery

The Plan covers:

- Surgery to repair a defect caused by an accidental injury
- Reconstructive surgery incidental to or following: surgery resulting from injury, sickness or disease of that part of the body
- Reconstructive surgery performed on an eligible dependent child who has a congenital disease or anomaly that has caused a functional defect, as determined by the attending physician
- Cosmetic surgery to correct a child's birth defect (other than a developmental defect), for dependent children
- Treatment of cleft lip and cleft palate for Members up to age 19 and all eligible dependent children (refer also to Section IV.M, Dental Care)
- Elimination or maximum feasible Treatment of portwine stain
- 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. These services are required under the Federal Women's Health and Cancer Rights Act of 1998.
- Orthognathic surgery that is considered Medically Necessary.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
If care is received:				
In an office setting	Annual Deductible applies. $30/$35 Copay per visit	Annual Deductible applies. $35/$40 Copay per visit	Annual Deductible applies. $65/$70 Copay per visit	Annual Deductible applies. $85/$90 Copay per visit
In an outpatient Hospital or surgical facility	Annual Deductible applies. $60 Copay per visit	Annual Deductible applies. $120 Copay per visit	Annual Deductible applies. $250 Copay per visit	Annual Deductible applies. 25% Coinsurance
In an inpatient Hospital setting	Annual Deductible applies. $100 Copay per visit	Annual Deductible applies. $200 Copay per visit	Annual Deductible applies. $500 Copay per visit	Annual Deductible applies. 25% Coinsurance

NOTES:

- The above benefit is for physician services related to reconstructive surgery. Benefits for inpatient Hospital services related to reconstructive surgery are listed under Inpatient Hospital, Section IV.T.
- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.
- Please refer to the Specific Benefit feature in this Summary of Benefits for more information.

NOT COVERED:

- Charges for cosmetic health services or any related services, except as provided above

Please refer to the Exclusions Section.

DD. Skilled Nursing Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Skilled Care ordered by a physician	Nothing	Nothing	Nothing	Nothing
Semiprivate Room and board	Nothing	Nothing	Nothing	Nothing
General nursing care	Nothing	Nothing	Nothing	Nothing
Prescription Drugs and supplies used during a covered Admission, and billed through the skilled nursing facility	Nothing	Nothing	Nothing	Nothing
Physical, occupational and speech therapy	Nothing	Nothing	Nothing	Nothing

NOTES:

- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.

NOT COVERED:

- Charges for maintenance or Custodial Care or long-term care
- Charges for forms of non-medical self-care or self-help training
- Please refer to the Exclusions Section.

EE. Specified Out-of-Network Services – Family Planning Services

The Plan covers:

The following services when You elect to receive them from an out-of-network Provider, at the same level of coverage the Plan provides when You elect to receive the services from Your PCC:

- Voluntary family planning of the conception and bearing of children
- Provider visits and tests to make a diagnosis of infertility
- Testing and Treatment of sexually transmitted diseases
- Testing for AIDS and other HIV-related conditions

Coverage level is the same as the corresponding benefit otherwise shown under **Cost Levels 1, 2, 3 and 4** in this Benefit Chart, depending on the type of service provided, such as Physician Services.

FF. Supplies, Durable Medical Equipment, Prosthetics and Orthotics

Covered items include but are not limited to the following:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Durable Medical Equipment (DME), which includes: wheel chairs, Hospital beds, ventilators, oxygen equipment, side rails, insulin pumps	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Medical supplies, which includes: splints, nebulizers, surgical stockings, casts, Medically Necessary post-surgical dressings and catheter kits	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Wigs coverage is limited to hair loss caused by alopecia areata – once per Benefit Year	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Covered prosthetics include: • breast prosthesis, • artificial limbs, and • artificial eyes	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Initial lenses after surgery for: • cataracts, • aphakia, (Does not include progressive or no-line bifocals or anti-reflective lenses)	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
The Plan will cover initial purchase of keratoconus lenses or the purchase of subsequent keratoconus lenses only when the physician provides a written statement verifying that there has been a change in the prescription.	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Hearing Aids that are Medically Necessary, including internal and external devices. Related fitting or adjustments are covered under office calls. Hearing Aids, batteries and accessories are eligible if purchased through a participating Provider or Hearing Aid supplier.	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Cochlear implants	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Enteral feedings, when the sole source of nutrition used to treat a life-threatening condition	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles. To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Medically necessary custom molded Foot Orthotics prescribed by a physician	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Diabetic supplies • blood/urine test strips • syringes/needles • cotton balls • alcohol swabs • glucose monitors • insulin pumps • lancets or other bloodletting devices • other diabetic supplies as deemed medically appropriate and necessary for Members with gestational, Type I or Type II diabetes	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	20% Coinsurance not subject to annual Deductibles To receive the best benefits, Members should use network Providers	Annual Deductible applies. 25% Coinsurance
Manual breast pumps	Nothing	Nothing	Nothing	Nothing

NOTES:

- Durable Medical Equipment, including Hearing Aids, is covered up to the Allowed Amount to rent or buy the item. Allowable rental charges are limited to the Allowed Amount to buy the item. The Claims Administrator has the right to determine whether an item will be approved for rental versus purchase.
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and Medically Necessary.
- For adults, Hearing Aids and Hearing Aid evaluation tests, which are to determine the appropriate type of aid, are covered up to a benefit limitation of once every three (3) years.
- For dependent children under age 19, Hearing Aids and Hearing Aid evaluation tests, which are to determine the appropriate type of aid, are covered as Medically Necessary.
- Coverage for Durable Medical Equipment will not be excluded solely because it is used outside the home.
- Please note that there may be differences among Claims Administrators in the way this benefit is administered.
- Contact your Claims Administrator (page 4), for general description of the coverage, level of coverage available, and criteria and procedures for any prior authorization.

NOT COVERED:

- Personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medical necessity
- Replacement or repair of covered items, if the items are 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen
- Over the counter supplies
- Other equipment and supplies that are not eligible for coverage. The Claims Administrator makes this determination and will notify You if the equipment is not eligible for coverage.
- Labor and related charges for repair estimates of any covered items which are more than the cost of replacement by an approved vendor

- Sales tax, mailing, delivery charges, service call charges
- Items which are primarily educational in nature or for vocation, comfort, convenience or recreation
- Modification to the structure of the home including, but not limited to, its wiring, plumbing, or charges for installation of equipment
- Vehicle, car or van modifications, including but not limited to hand brakes, hydraulic lifts and car carriers
- Charges for services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, communication devices, and home blood pressure kits
- Charges for lenses, frames, contact lenses, or other optical devices or professional services for the fitting and/or supply thereof, including the surgical Treatment of refractive errors such as radial keratotomy
- Duplicate equipment, prosthetics, or supplies
- Charges for arch supports, and orthopedic shoes and Foot Orthotics, including biomechanical evaluation and negative mold foot impressions, except as specified above
- Enteral feedings and other nutritional and electrolyte substances, except for conditions that meet medical necessity criteria as determined by the Claims Administrator
- Oral dietary supplements, except for phenylketonuria (PKU)
- Please refer to the General Exclusions Section.

GG. Ventilator Dependent Communication Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Up to 120 hours per confinement for services provided by a private duty nurse or personal care assistant for a ventilator-dependent patient in a Hospital. The private duty nurse will perform only the services of communicator or interpreter for the ventilator-dependent patient during the transition period to assure adequate training of the Hospital staff to communicate with the ventilator-dependent patient	Nothing	Nothing	Nothing	Annual Deductible applies. 25% Coinsurance

NOTES:

- Ventilator-dependent communication services are limited to a combined total of 120 hours per Admission.
- You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.

NOT COVERED:

- Charges for private-duty nursing, except as specified above
- Please refer to the Exclusions Section.

HH. Well-Child Care

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Pediatric preventive services	Nothing	Nothing	Nothing	Nothing
Developmental assessments	Nothing	Nothing	Nothing	Nothing
Medically Necessary immunizations for a child from birth to age 18	Nothing	Nothing	Nothing	Nothing

NOTES:

- Benefits for routine preventive care for a child age six (6) or older are listed under the Preventive Care Section IV.BB, except as specified above. You pay all charges when You use a Provider without authorization by Your Primary Care Clinic.

NOT COVERED:

- Please refer to the Exclusions Section

II. Women's Preventive Health Care Services

The Plan covers:

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Screening for gestational diabetes mellitus (GDM)	Nothing	Nothing	Nothing	Nothing
Human papillomavirus (HPV) testing	Nothing	Nothing	Nothing	Nothing
Counseling for sexually transmitted infection (STI)	Nothing	Nothing	Nothing	Nothing
Counseling and screening for human immunodeficiency virus (HIV)	Nothing	Nothing	Nothing	Nothing
Counseling and screening for interpersonal and domestic violence	Nothing	Nothing	Nothing	Nothing
Breastfeeding support, supplies and counseling	Nothing	Nothing	Nothing	Nothing
Well-woman visits	Nothing	Nothing	Nothing	Nothing
Contraceptive methods, female sterilization and counseling	Nothing	Nothing	Nothing	Nothing

For contraceptive prescription medications, please see Section IV. AA. Prescription Drugs and Services.

NOTES:

- Please note that there may be differences among Claims Administrators in the way this benefit is administered. Members should contact their Claims Administrator with questions regarding coverage levels for specific services, equipment, and prescription drugs.
- Syphilis screening for non-pregnant persons

- Coverage for an annual preventative mammogram screening using digital breast tomosynthesis (3D), if the enrollee is at risk for breast cancer defined as: Having a family history with one or more first or second-degree relatives with breast cancer; testing positive for BACRA1 or BRACA2 mutations; having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology: or having a previous diagnosis of breast cancer.
- Routine cancer screening including pap smears, mammograms, and surveillance tests for ovarian cancer for women who are risk for ovarian cancer.

V. Miscellaneous coverage features

A. AUTHORIZED CARE OUTSIDE THE SERVICE AREA

For an Illness, injury or condition for which services may be required and the Member will be temporarily leaving the service area, the Plan covers urgently needed care from Nonparticipating Providers if the Member is under the care of a PCC who has authorized that care. Coverage may include professional services from a non-network physician and Hospital services, which are for scheduled care which is immediately required and cannot be delayed. (For emergency services outside the network, please see Section IV. N.) Please refer to the specific benefit feature in this Summary of Benefits to determine coverage levels.

B. HEALTH EDUCATION

In addition to diabetes outpatient self-management and education benefits described in Section IV.X. Outpatient Hospital, the Plan covers education provided at the PCC for preventive services at no cost and education for the management of other chronic medical conditions at the Copayment or Deductibles level associated with Your PCC.

C. TOBACCO REDUCTION PROGRAM

PreferredOne partners with Quit for Life®, a free, confidential, self-referral program that helps you successfully quit your tobacco habit. The program includes expert Quit Coaches® who support your tobacco reduction journey by phone and/or text messages; membership to a private, online community with different learning activities, progress tracking, and a support network. The program works with you to create an easy-to-follow plan to help you quit tobacco use - for life. Access Quit for Life® by phone, web or mobile app. 1-866-784-8454 or www.quitnow.net.

Blue Cross offers quitting tobacco support that provides a behavior change program to support members who want to reduce tobacco use. This service is available to all members 18 years of age or older, including those who use smokeless tobacco products. Call toll free at 1-888-662-BLUE (2583) to get started.

HealthPartners offers A Call to Change…Partners in Quitting®, an innovative course designed to help smokers prepare for and set a quit date and practice skills to manage high-risk situations after quitting. A Certified Wellness and Health Coach will work with You one-to-one over the phone to help You quit smoking. For more information and to register, please call 952-883-7800 or 1-800-311-1052 (outside the metro area) or 952-883-7498 (TTY).

VI. Exclusions

The Plan does not pay for:

1. charges for services that are eligible for payment under a Workers' Compensation law, employer liability law, or any similar law;
2. services for or related to Treatment of Illness or injury which occurs while on military duty that are recognized by the Veterans Administration as services related to service-connected injuries;
3. charges for services for or related to reconstructive surgery or cosmetic health services, except as specified in the Benefit Chart;
4. charges for any Treatments, services or supplies which are not Medically Necessary; care that is Investigative, custodial, or not normally provided as preventive care or Treatment of an Illness; charges for non-Covered Services, except for certain routine care for approved clinical trials;
5. charges for therapeutic acupuncture except for conditions that meet medical necessity criteria as described by the medical policy on acupuncture for each Claims Administrator;
6. charges for marital, relationship, training services and religious counseling; charges for sex therapy in the absence of a diagnosed mental disorder;
7. charges for recreational or educational therapy, or forms of nonmedical self-care or self-help training, including, but not limited to, health club Memberships, smoking cessation programs (unless Medically Necessary, appropriate Treatment, and a Plan-approved program), and any related diagnostic testing; (please see Section V.C. for information regarding tobacco reduction programs);
8. charges for lenses, frames, contact lenses or other fabricated optical devices, or professional services for the fitting or supply thereof; keratotomy and keratorefractive surgeries except as medically necessary.
9. charges for services that are normally provided without charge, including services of the clergy that are normally provided without charge;
10. charges for autopsies;
11. charges by a health professional for telephone or e-mail consultations (in certain cases, HealthPartners Members may have coverage for e-visits and scheduled telephone consultations);
12. charges for major organ and bone marrow transplants, including all transplant-related consultations/evaluations, follow-up Treatment, exams and drugs received within 365 days following transplant, except as specified in the Benefit Chart, including drug therapies, for conditions/diagnosis not specifically noted in the Benefit Chart;
13. chemotherapy or radiation therapy together with all related services, supplies, drugs and aftercare, when the administration of such is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt of autologous, allogeneic or syngeneic stem cells, whether derived from the bone marrow or the peripheral blood, unless the chemotherapy/radiation is specifically related to a transplant for an approved condition/diagnosis noted in the Benefit Chart. Refer to Organ and Bone Marrow Transplant Coverage, Section IV.U, for specific coverage, limitations and exclusions;
14. nonprescription (over-the-counter) drugs or medicines, vitamin therapy or Treatment, and appetite suppressants, Prescription Drugs that have not been classified as effective by the FDA, bioengineered drug therapy that has not received FDA approval for the specific use being requested, except for off-label use in cancer Treatment, as specified by law, and Prescription Drugs that are not administered according to generally accepted standards of practice in the medical community;

15. charges for services a Provider gives him/herself or to a close relative (such as spouse, brother, sister, parent or child);
16. charges for dental or oral care except for those specified in the Benefit Chart; charges for any appliance or service for or related to dental implants, including Hospital charges;
17. charges for personal comfort items such as telephone, television, barber and beauty services, guest services;
18. charges for Hospital room and board expense that exceeds the Semiprivate Room rate unless a private room is approved by the Claims Administrator as Medically Necessary;
19. charges for services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, and home blood pressure kits;
20. charges for arch supports or orthopedic shoes, including biomechanical evaluation and negative foot mold impressions, except as specified in the Benefit Chart;
21. charges for or related to transportation other than ambulance service to the nearest medical facility equipped to treat the Illness or injury, except as specified in the Benefit Chart;
22. charges for services provided before Your coverage is effective; services provided after Your coverage terminates, even though Your Illness started while coverage was in force (see Section III.B.12 for information on inpatient extension of benefits);
23. charges for private-duty nursing, except ventilator dependent communication services;
24. charges for services or confinements ordered by a court or law enforcement officer that the Claims Administrator determines are not Medically Necessary (please see Sections IV.J. and IV.W. for further information);
25. charges for weight loss, drugs and programs, including program fees or dues, nutritional supplements, food, appetite suppressants, vitamins and exercise therapy unless Medically Necessary, appropriate Treatment, and a Plan-approved program;
26. charges for maintenance or custodial therapy; charges for rehabilitation services, such as physical, occupational, and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time;
27. charges for nursing services to administer home infusion therapy when the patient or other caregiver can be successfully trained to administer therapy; services that do not involve direct patient contact, such as delivery charges and recordkeeping;
28. charges for health services for non-emergency Treatment of Mental Illness, chemical dependency, and chiropractic provided by a Provider who is not affiliated with Your PCC, or not in the Chemical Dependency, Mental Health, or Chiropractic Networks, unless specifically authorized by the Claims Administrator;
29. charges for diagnostic Admission for diagnostic tests that can be performed on an outpatient basis;
30. charges for Treatment, equipment, drug, and/or device that the Claims Administrator determines do not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or Treatment; charges for services for or related to systemic candidiasis, homeopathy, immuno-augmentative therapy or chelation therapy that the Claims Administrator determines is not Medically Necessary;
31. charges for physical exams for purpose of obtaining employment, licensure or insurance, unless otherwise Medically Necessary;

32. services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits;
33. services to hold or confine a person under chemical influence when no medical services are required regardless of where the services are received;
34. charges for services for or related to growth hormone, except that replacement therapy is eligible for conditions that meet medical necessity criteria as determined by the Claims Administrator prior to receipt of the services;
35. charges for reversal of sterilization;
36. charges for any service related to artificial insemination and any form of assisted reproductive technologies (ART) which includes in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT); intracytoplasmic sperm injection (ICSI). Services associated with non-covered services including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
37. charges for donor ova or sperm acquisition, retrieval or storage;
38. charges for drug therapies related to infertility[2];
39. Charges for Surrogate Pregnancy and related obstetric/maternity benefits if the surrogate is not a member
40. Charges for elective home births.
41. charges for travel, transportation, or living expenses, whether or not recommended by a physician, except as described in this document;
42. charges that are eligible, or paid under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges for services that are applied toward any Copay or Coinsurance requirement of such a policy;
43. massage therapy for the purpose of a Member's comfort or convenience;
44. services that are rendered to a Member, who also has other primary insurance coverage for those services and who does not provide the Claims Administrator the necessary information to pursue Coordination of Benefits, as required by the Plan;
45. the portion of a billed charge for an otherwise covered service by a Provider, which is in excess of the Allowed Amount;
46. nutritional supplements, over the counter electrolyte supplements and infant formula, and breast milk, except as required by Minnesota law or the Claims Administrator's medical policy; oral amino based elemental formulae are covered if they meet the Medical Necessary criteria of the Claims Administrator;
47. genetic counseling and genetics studies which are not Medically Necessary;
48. replacement of a Prescription Drug due to loss, damage, or theft; (certain exceptions apply – please call Your Claims Administrator if You have questions);
49. dental implants and any associated services and/or charges, except when related to services for cleft lip and palate that are scheduled or initiated prior to a Member turning age 19 or for eligible dependent children.
50. Charges for weight loss surgery received from a provider who does not participate in the designated weight loss network of the Claims Administrator.

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[2] HealthPartners Members may be covered for additional Treatment. Please consult with Your PCC regarding Treatment options. Please refer to IV.Z, Physician Services, for information about coverage for the Treatment of infertility.

VII. Health Education Resources for Advantage Members

The following health education resources are covered benefits options for all Advantage Members. Please note that all preventive care services are covered at 100 percent (see details on Preventive Care coverage at Section IV.BB). For additional information on health and wellbeing resources, contact Your individual health Plan. Some Plans offer their Members resources such as classes, websites, nurse lines, retail and service discounts, and health education literature.

- **Back Health (Chiropractic Care)**

  The Plan covers chiropractic care rendered to diagnose and treat acute neuromuscular-skeletal conditions. See additional coverage details at Section IV.K.

- **Health Education**

  The Plan covers diabetes outpatient self-management training and education, including medical nutrition therapy. In addition, the Plan also covers education provided at the Primary Care Clinic for preventive services and education for the management of other chronic medical conditions. See Outpatient Hospital (Section IV.X) and Physician Services (Section IV.Z), as well as Miscellaneous Coverage Features (Section V.).

- **Tobacco Reduction**

  Quitplan® services are available through ClearWay Minnesota to all Minnesotans at 1-888-354-PLAN (7526). This help line will assist Members of all health Plans in finding smoking cessation information and counseling. In addition, certain of the Claims Administrators have help lines for smoking cessation. (See Section V.C.)

  With a written physician's prescription, the Advantage Plan will cover Formulary nicotine replacement therapies. There will be no Copayment for Formulary nicotine replacement therapies for employees and dependents.

- **Weight Management**

  The Advantage Plan may cover a weight loss program if it is Medically Necessary, appropriate Treatment and Plan-approved.

- **Disease and Condition Management**

  The condition of Your health impacts so many aspects of life, a voluntary disease management program is offered to Advantage Members who may qualify due to certain health/medical situations such as diabetes, heart disease, and asthma. This program provides personalized support to help You manage Your condition. Members who are eligible for this program are contacted by program nurses and offered enrollment in the program. This program is not a substitute for the care You should be receiving from Your doctor. Instead, it is designed to help You reach Your health goals.

  Eligible Members are identified by claims data submitted to each Plan's disease management program. All information is private and confidential and is used only to support the work of the disease management programs. Your employer is unaware of Your participation in any disease management program.

- **Health Assessment**

  Health assessments are a benefit for Advantage Members. They are an educational tool by which Members may learn more about their personal health. Health assessments identify behaviors that are modifiable and, if modified, can lead to improved health. Participation is voluntary, and the health assessment is completed on a secure Vendor website accessible with a login ID and password. Members will receive a personalized, confidential report from the Vendor, and, if a health condition is noted as the result of the assessment (and if the Member agrees) a health professional will follow up to discuss specific action plans. The health professional may recommend appropriate programs such as disease and condition management, weight management, nutrition classes, behavioral health, exercise, tobacco cessation, and others offered by the Vendor and/or the Member's health Plan and employee assistance program.

  Completion of the on-line health assessment and acceptance of a call from a health professional, when appropriate, during the designated open enrollment period will result in a reduction in the office visit Copays for the Member and eligible dependents.

VIII. Cost sharing feature: What You pay

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Individual Annual Deductible	$250.00	$400.00	$750.00	$1500.00
Family Annual Deductible	$500.00	$800.00	$1500.00	$30001.00
Individual Annual Out-of-Pocket Limit for Prescription Drugs	$1050.00	$1050.00	$1050.00	$1050.00
Family Annual Out-of-Pocket Limit for Prescription Drugs	$2100.00	$2100.00	$2100.00	$2100.00
Individual Annual Out-of-Pocket Limit for all other services	$1700.00	$1700.00	$2400.00	$3600.00
Family Annual Out-of-Pocket Limit for all other services	$3400.00	$3400.00	$4800.00	$7200.00
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

When You use Your PCC You are also responsible for:

- Copays: the level of Your Copayment is based on whether You completed the Health Assessment during each Open Enrollment;
- Deductibles and Coinsurance;
- Charges for non-Covered Services;
- Charges for services that are Investigative or not Medically Necessary;
- Charges for which You were notified before You received services that they were not covered and You agreed in writing to pay;
- The Prescription Drug Out-of-Pocket Maximum and the Out-of-Pocket Maximum for all other services are per year maximums and apply across all cost levels.

IX. Coordination of Benefits

This section applies when You have health care coverage under more than one Plan, as defined below. If this section applies, You should look at the Order of Benefits Rules 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.

A. Definitions

These definitions apply only to this section.

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

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

   b) coverage under a government Plan or one required or provided by law

      "Plan" does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include Medicare (Title XVIII, United States Code, as amended from time to time) for Medicare benefits paid or payable to any person for whom Medicare is primary. "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program. (Please note that if Your other insurance is Medicare, You should contact Your Claims Administrator to determine which Plan is primary.)

2. "This Plan" means the part of the Plan 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 Plans, this Plan may be a primary Plan to some Plans, and may be a secondary Plan to other Plans.

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

   The difference between the cost of a private and a semiprivate Hospital room is not considered an allowable expense unless Admission to a private Hospital room is Medically Necessary under generally accepted medical practice or as defined under this Plan.

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

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

B. Order of Benefits Rules

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

   a) the other Plan has rules coordinating its benefits with this Plan's benefits; and
   b) the other Plan's rules and this Plan's rules, in part 2 below, require this Plan to determine benefits before the other Plan.

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

   a) Nondependent/dependent. The Plan that covers the person as an employee, Member, or subscriber (that is, other than as a dependent) determines its benefits before the Plan that covers the person as a dependent.
   b) Dependent child of parents not separated or divorced. When this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

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

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

   c) Dependent child of parents who are divorced or separated. If two or more Plans cover a dependent child of divorced or separated parents, the Plan determines benefits in this order:

      i) first, the Plan of the parent with custody of the child;
      ii) then, the Plan that covers the spouse of the parent with custody of the child;
      iii) finally, the Plan that covers the parent not having custody of the child.

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

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

   e) Longer/shorter length of coverage. If none of the above rules 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 the shorter time.

C. Effect on Benefits of This Plan

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

2. Reduction in this Plan's benefits. When the sum of:

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

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

D. 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. The Claims Administrator does not need to tell, or get the consent of, any person to do this unless applicable federal or state law prevents disclosures of information without the consent of the patient or patient's representative. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

E. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If this happens, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. The Claims Administrator 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.

F. Right of Recovery

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

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

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

X. General Provisions

A. Entire Contract

This Summary of Benefits, your enrollment form, and the ID card make up the entire Plan of coverage. Your employer is the Plan Sponsor for Your coverage Plan. Minnesota Management and Budget has discretionary authority to determine Your eligibility for participation in the program.

B. Time Limit for Misstatements

If there is any misstatement in the written application You complete, Minnesota Management and Budget cannot use the misstatement to cancel coverage that has been in effect for two years or more. This time limit does not apply to fraudulent misstatements.

C. Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:01 a.m. and ends at 12:01 a.m. the following day.

D. LEGAL ACTIONS:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

XI. Filing a claim

A. Filing a Claim

You are not responsible for submitting claims for services received from Primary Care Providers. These Providers will submit claims directly to the Claims Administrator for You and payment will be made directly to them. If You receive services from Nonparticipating Providers, You may have to submit the claims Yourself. If the Provider does not submit the claim for You, send the claim to the Claims Administrator at the address provided in the "Specific Information About the Plan" section.

Claims should be filed in writing within 90 days after a covered service is provided. If this is not reasonably possible, the Plan will accept claims for up to 12 months after the date of service. Normally, failure to file a claim within the required time limits will result in denial of Your claim. These time limits are waived if You cannot file the claim because You are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that You have incurred a covered expense that is eligible for reimbursement.

The Claims Administrator will notify You of the resolution of the claim on an Explanation of Benefits (EOB) or Explanation of Health Care Benefits (EHCB) form within 90 days of the date the Claims Administrator receives the claim and all information required to process the claims. (For Blue Cross and HealthPartners Members, an EOB will be sent only if there is a Member liability.) Under special circumstances, the time period for making a decision may be extended to 180 days after the Claims Administrator receives the claim and all information

required to process the claim. If You do not receive a written explanation within 90 days (or 180 days if there has been an extension), You may consider the claim denied, and You may request a review of the denial.

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

B. Release of Records

You agree to allow all health care Providers to give the Claims Administrator needed information about the care they provide to You. The Claims Administrator may need this information to process claims, conduct utilization review and quality improvement activities, and for other health Plan activities as permitted by law. The Claims Administrator keeps this information confidential, but the Claims Administrator may release it if You authorize release, or if state or federal law permits or requires release without Your authorization. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of Your claim.

C. Privacy of Health Records

Your health information is private data. None of the information about Your health status or claims which has been gathered by the Claims Administrator in order to adjudicate claims can be disseminated without Your consent unless You are notified at the time of open or special enrollment [62D.145]

D. Whom the Claims Administrator Pays

When You receive Covered Services from Your PCC, from a Provider with authorization from Your Primary Care Clinic, or when the Provider has an agreement with the Claims Administrator, the Claims Administrator pays the Provider.

E. Prompt Claims Payment

The Claims Administrator will pay claims in a timely manner. If a complete claim is properly submitted and doesn't require additional documentation or special review or Treatment (a "clean claim"), the Claims Administrator must either pay or deny the claim within 30 calendar days of the date it was received by the Claims Administrator or the Claims Administrator is required to pay interest to the person entitled to payment at a rate of 1.5% per month (or part of a month) for the period beyond 30 days until the claim is paid or denied.

XII. Disputing a claim

A. Medical Utilization Review

Some services or facility Admissions require utilization review. Participating Providers will request medical utilization review for You. If You are requesting services from a Nonparticipating Provider, You may request medical utilization review by calling the telephone number on the back of Your identification card.

Definitions

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

Attending health care professional means the health care professional providing care within the scope of practice and with primary responsibility for the care provided to an enrollee; specifically physicians, chiropractors, dentists, mental health professionals, podiatrists, and advanced practice nurses.

Procedure

When medical utilization review is required, the Claims Administrator will notify You and Your attending health care professional or Hospital of the decision within 10 business days of the request provided that all information reasonably necessary to make a determination on Your request has been made available to them.

Your attending health care professional may request an expedited review. The Claims Administrator will notify You and Your attending health care professional or Hospital of the decision as soon as the Member's medical condition requires, but no later than 72 hours from the initial request.

Medical utilization review decisions may be appealed. You or Your attending health care professional may appeal the decision of the Claims Administrator to not authorize services in writing or by telephone. The Claims Administrator will notify You and Your attending health care professional of its determination within 30 days of receipt of Your appeal. They may take up to 14 additional days to make a decision due to circumstances outside their control. If they take more than 30 days to make a decision, they will notify You in advance of the reasons for the extension.

You or Your attending health care professional may request an expedited appeal. When an expedited appeal is complete, the Claims Administrator will notify You and Your attending health care professional of the decision as expeditiously as the medical condition requires, but no later than 72 hours from receipt of the expedited appeal request.

The request for appeal of a medical utilization review determination should include the enrollee's name, identification number and group number; the actual service for which coverage was denied; a copy of the denial letter; the reason why You or Your attending health care professional believe the service should be provided; any available medical information to support Your reasons for reversing the denial; and any other information You believe will be helpful to the decision maker. You may request an External Review of the final decision by following the External Review process described below.

B. Complaints and Appeals

(1) Claims Administrators Appeal Process

The Claims Administrators also have a process to resolve complaints. You may call or write them with Your complaint. They will send a complaint form to You upon request. If You need assistance, they will complete the written complaint form and mail it to You for Your signature. They will work to resolve Your complaint as soon as possible using the process outlined below. If Your complaint concerns a health care service or claim, You may request an external review of the final decision made about Your appeal after You have exhausted the appeal process.

(a) Oral Complaints

If You call or appeal in person to notify the Claims Administrator that You would like to file a complaint, they will try to resolve Your oral complaint within 10 calendar days. If the resolution of Your oral complaint is wholly or partially adverse to You, they will provide You a complaint form that will include all the necessary information to file Your complaint in writing. If You need assistance, they will complete the written complaint form and mail it to You for Your signature.

(b) Written Complaints

You may submit Your complaint in writing, or You may request a complaint form that will include all the information necessary to file Your complaint. The Claims Administrator will notify You of receipt of Your written complaint. They will notify You of their decision and the reasons for the decision within 30 days of receiving Your complaint and all necessary information. If they are unable to make a decision within 30 days due to circumstances outside their control, they may take up to 14 additional days to make a decision. If they take more than 30 days to make a decision, they will inform You in advance of the reasons for the extension.

(c) Appeals

If the decision regarding a complaint is partially or wholly adverse to You, You may file an appeal of the decision in writing and request either a hearing or a written reconsideration. If You request a hearing, You or any person You choose may present testimony or other information. The Claims Administrator will provide You written notice of their decision and all key findings within 45 days after receipt of Your written request for a hearing. If You request a written reconsideration, You may provide any additional information You believe is necessary. You have a right to review Your claim file and You have the right to request and receive a copy of documents, records, and other information relevant to Your Claim. The Claims Administrator will provide You written notice of its decision and all key findings within 30 days after receipt of Your request for a written reconsideration. If You request, they will provide You a complete summary of the appeal decision.

(2) MMB Appeal Process

If a Member's claim is denied initially by the Claims Administrator, the Member may appeal the decision to MMB, who will review the claim. You may appeal any adverse benefit decision, including a rescission of coverage for You or Your dependent. You have a right to review Your claim file and You have the right to request and receive a copy of documents, records, and other information relevant to Your claim. You have the right to present testimony or other information. As part of this review, MMB may consult with the Department of Health to review (or discuss) such appeals. Should You wish to initiate such an appeal, please call the Employee Insurance Section of MMB at (651) 355-0100, or write to:

Minnesota Management and Budget
Employee Insurance Section
400 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

An appeal form and Consent for Release of Medical Records form will be sent to You. There is no charge to participate in this appeal process.

(3) Minnesota Department of Health (for member of HealthPartners or Preferred One) or the Department of Commerce (for BCBSMN Members)

You have the right to request an appeal by the Minnesota Department of Health (for member of HealthPartners or Preferred One) or the Department of Commerce (for BlueCross BlueShield Members). If You wish to exercise that right, please contact the Employee Insurance Section of the Minnesota Management and Budget at the

address referenced in B(2) above. Please also refer to the Department of Health's web site at http://www.health.state.mn.us/divs/hpsc/mcs/complaint.htm.

(4) External Review of Denied Claims

If a Member's claim is denied initially and receives an adverse determination of an internal appeal to the Claims Administrator, the Member may request an external review by an independent company that contracts with the State of Minnesota to review appeals made by individuals. Members must exhaust the appeal process provided by their Claims Administrator before they may submit an External Review.

Members desiring such an independent external review should follow the directions found at www.health.state.mn.us/divs/hpsc/mcs/external.htm. They should send the appropriate forms to the Employee Insurance Section of Minnesota Management and Budget, which is charged with beginning the process of requesting the external review from the reviewer.

A $25 filing fee is required; this fee is refundable if the external appeal is reversed. In cases of financial hardship, the Member can request a waiver of the fee by providing sufficient information to support the waiver request. No enrollee may be subject to filing fees totaling more than $75 per calendar year.

External review is normally completed within 40 days; however, in situations where delay could endanger the Member's health, an expedited appeal may be filed by phone, fax or email and will be handled within 72 hours. A written determination will be issued to each party within the appropriate time frame.

The Member may provide any information, supporting documentation, testimony and argument for the expedited review; however the primary responsibility to submit a complete case file rests with the Plan and its Claims Administrator. Providing inadequate information can result in the overturning of a denial. The reviewer may request additional information from the Plan within 10 days of the initial filing.

The decision of the independent company is binding on the Plan, which is required to comply with the decision promptly. The Member, however, is not bound by the reviewer's decision.

XIII. Plan Amendments

All changes to the Plan must be approved by the Claims Administrator and Minnesota Management and Budget and attached to the Plan Document. No agent can legally change the Plan or waive any of its terms.

In applying any Deductible or waiting period, the Plan gives credit for the full or partial satisfaction of the same or similar provisions under the prior contract.

Nothing in the contract between the State of Minnesota and the Claims Administrator shall modify, limit or restrict the authority of the Commissioner of MMB as permitted by law to enter into contracts with other Claims Administrators or Providers; to remove a Claims Administrator from the State Employee Group Insurance Program; and to limit the geographic area serviced by the Claims Administrator covering employees under the State Employee Group Insurance Program.

XIV. Reimbursement and Subrogation

If the Claims Administrator pays medical benefits for medical or dental expenses You incur as a result of any act of a third party for which the third party is or may be liable, and You later obtain full recovery, You are obligated

to reimburse the Claims Administrator for the benefits paid in accord with Minnesota statutes 62A.095 and 62A.096, the laws related to subrogation rights. “You” means You and Your covered spouse and dependents for purposes of this Section.

The Claims Administrator’s right to reimbursement and subrogation is subject to subtraction for actual monies paid to account for the pro rata share of Your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the Claims Administrator is separately represented by its own attorney.

If the Claims Administrator is separately represented by an attorney, the Claims Administrator may enter into an agreement with You regarding Your costs, disbursements and reasonable attorney fees and other expenses. If an agreement cannot be reached on such allocation, the matter shall be submitted to binding arbitration.

Nothing herein shall limit the Claims Administrator’s right to recovery from another source which may otherwise exist at law. For purposes of this provision, full recovery does not include payments made by the Claims Administrator or for Your benefit. You must cooperate with reasonable requests of the Claims Administrator to assist it in protecting its legal rights under this provision.

If You make a claim against a third party for damages that include repayment for medical and medically related expenses incurred for Your benefit, You must provide timely written notice to the Claims Administrator of the pending or potential claim. The Claims Administrator, at its option, may take such action as may be appropriate and necessary to preserve its rights under this reimbursement and subrogation provision, including the right to intervene in any lawsuit You have commenced with a third party.

Notwithstanding any other law to the contrary, the statute of limitations applicable to the Claims Administrator’s rights for reimbursement or subrogation does not commence to run until the notice has been given.

XV. Definitions

These terms have special meaning in this benefit booklet.

Admission

A period of one or more days and nights while You occupy a bed and receive inpatient care in a facility.

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 specified 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, and the Claims Administrator uses a reasonable allowance to establish a per-service Allowed Amount for such Covered Services. Through settlements, rebates, prospective payments and other methods, the Claims

Administrator may adjust the amount due to a participating Provider. These adjustments will not affect you 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 Sponsor, 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.

Audiologist A person who has a certificate of clinical competence from the American Speech-Language-Hearing Association.

Audiologist Evaluation An assessment by a licensed Audiologist or Otolaryngologist of communication problems caused by hearing loss.

Average Semiprivate Room Rate The average rate charged for Semiprivate Rooms. If the Provider has no semi-private rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

Benefit Chart The charts in Sections IV and VIII of this benefit booklet that list specific benefit amounts for Covered Services.

Benefit Year The period from the effective date of the class of employees to the effective date in the next year as determined by Minnesota Management and Budget.

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

Claims Administrator Blue Cross and Blue Shield of Minnesota, HealthPartners Administrators, Inc., PreferredOne Administrative Services, Inc., or CVS Caremark.

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 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.

For Covered Services from Nonparticipating Providers, Coinsurance is calculated based on the Allowed Amount. In addition, You are responsible for any excess charge over the Allowed Amount.

Your Coinsurance and Deductibles 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 Deductibles calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Continuous Care

Two to twelve hours of service per day provided by a registered nurse, licensed practical nurse or home health aide, during a period of crisis in order to maintain a Terminally Ill Patient at home. Less than two hours of service is considered to be part-time.

Continuous Coverage

The maintenance of continuous and uninterrupted Creditable Coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained Continuous Coverage if the enrollment date for coverage is within 63 days of the termination of his or her Creditable Coverage.

Copay or Copayment

The dollar amount You must pay for certain Covered Services. The Benefit Chart lists the Copays and shows the 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.

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.

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, medical assistance, general assistance medical care, the 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, or a Peace Corps health Plan.

Custodial Care

Services that the Claims Administrator determines are for the primary purpose of meeting personal needs. These services can be provided by persons without professional skills or training. Custodial care does not include Skilled Care. Custodial care includes giving medicine that can usually be taken without help, preparing special foods, and helping You to walk, get in and out of bed, dress, eat, bathe, and use the toilet.

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 Deductibles 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 Deductibles calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Durable Medical Equipment

Medically Necessary equipment that the Claims Administrator determines is:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. useful only to a person who is ill; and
4. prescribed by a physician.

Durable Medical Equipment does not include such things as:

1. vehicle lifts;
2. waterbeds;
3. air conditioners;
4. heat appliances;
5. dehumidifiers; and
6. exercise equipment.

Foot Orthotic

A Foot Orthotic is a rigid or semi-rigid orthopedic appliance or apparatus worn to support, align and/or correct deformities of the lower extremity.

Formulary

A comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists. A drug Formulary serves as a guide for the Provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.

Hearing Aid

A monaural Hearing Aid, set of binaural Hearing Aids, or other device worn by the recipient to improve access to and use of auditory information.

Hearing Aid Accessory

Chest harness, tone and ear hooks, carrying cases, and other accessories necessary to use the Hearing Aid, but not included in the cost of the Hearing Aid.

Home Health Agency

A Provider that is a Medicare-certified Home Health Agency. Home Health Agencies send 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. Individuals who elect to receive hospice services have chosen comfort care measures and supportive services rather than curative Treatment. You may withdraw from the hospice program at any time and may re-enter the program once.

Hospital

A facility that is licensed or regulated as an acute care facility and staffed by physicians. Hospitals provide inpatient and outpatient care 24 hours a day.

Illness

A sickness, injury, pregnancy, mental Illness, chemical dependency, or condition involving a physical disorder.

Investigative

As determined by the Claims Administrator, a drug, device or medical Treatment or procedure is Investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); if the drug or device or medical Treatment or procedure

is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical Treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of Treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and

3. Whether there are consensus opinions of national and local health care Providers in the applicable specialty as determined by a sampling of Providers, including whether there are protocols used by the treating facility or another facility, or another facility studying the same drug, device, medical Treatment or procedure.

   Notwithstanding the above, the Claims Administrator will not consider a drug, device or medical Treatment or procedure Investigative if it shows sufficient promise. In order to show sufficient promise, the Claims Administrator must determine, on a case-by-case basis, that a drug, device or medical Treatment or procedure meets the following criteria:

   a. reliable evidence preliminarily suggests a high probability of improved outcomes compared to standard Treatment (e.g., significantly increased life expectancy or significantly improved function); and
   b. reliable evidence suggests conclusively that beneficial effects outweigh any harmful effects; and
   c. if applicable, the FDA has indicated that approval is pending or likely for its proposed use;
   d. reliable evidence suggests the drug, device or Treatment is medically appropriate for the Member.

      When the Claims Administrator determines whether a drug, device, or medical Treatment shows sufficient promise, reliable evidence will mean only published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocols or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical Treatment or procedure, which describes among its objectives, determinations of safety, or efficacy in comparison to conventional alternatives, or toxicity or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical Treatment or procedure.

      Reliable evidence shall 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 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.

Look Back Method An ongoing and rolling method used to determine if You are Full-time for ACA purposes and therefore are eligible for health coverage. The Look Back consists of three periods: The Measurement Period is a one year period during which the hours You provide are tracked. Your Appointing Authority totals the hours You provided during the associated Administrative Period. During the subsequent one year Stability Period, You will be offered health coverage if You were measured Full-time during the Measurement Period (or if You are eligible under the applicable labor agreement or compensation plan) If You are measured as Full-time during a Measurement Period, You will receive health coverage during the associated Stability Period, regardless of the number of hours You work, unless You no longer provide hours to any Appointing Authority within the Control Group, or if You experience a change in employment status and are measured again and found to be not Full-time.

Mail Order Pharmacy An authorized pharmacy that dispenses Prescription Drugs through the U.S. Mail.

Maintenance Care Care that is neither habilitative nor rehabilitative that is not expected to make measurable or sustainable improvement within a reasonable period of time, unless the care is medically necessary and part of specialized therapy for the member's condition.

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

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

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

1. be consistent with generally accepted practice parameters as determined by health care Providers in the same or similar general specialty as typically manages the conditions, procedures or Treatment at issue; and
2. help restore or maintain the individual's health; or
3. prevent deterioration of the individual's condition; or
4. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Members Members are eligible employees and their dependents who are participating in the Plan.

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

Nonparticipating Provider Providers who have not signed an agreement with the Claims Administrator or its subsidiaries.

OB/GYN Network A Provider network made up of obstetricians and gynecologists that female Members may obtain certain services from without a referral from their primary care physician. Please consult Your directory for a listing of these Providers.

Otolaryngologist A physician specializing in the diseases of the ear and larynx who is certified by the American Board of Otolaryngology or eligible for board certification.

Out-of-Pocket Maximum (annual) The most each person must pay each year toward the Allowed Amount for Covered Services. After a person reaches the Out-of-Pocket Maximum, the Plan pays 100 percent of the Allowed Amount for Covered Services for that person for the rest of the year. The Benefit Chart lists the Out-of-Pocket Maximum amounts. The following items are applied to the Out-of-Pocket Maximum:

1. Coinsurance
2. Deductible
3. Copays
4. penalties for not giving the Claims Administrator preadmission notification

Prescription Drug Out-of-Pocket expenses do not apply to this Out-of-Pocket maximum, except those dispensed and used during an inpatient Admission. There is a separate Out-of-Pocket Maximum for Prescription Drugs. The benefit chart lists this amount.

Participating Transplant Center A Hospital or other institution that has contracted with the Claims Administrator to provide organ or bone marrow transplant, stem cell support, all related services and aftercare.

Plan The Plan of benefits established by the Plan Sponsor.

Plan Sponsor The State of Minnesota (also referred to as the Plan Administrator.)

Preadmission Notice The process to certify that an Admission is Medically Necessary before the patient is admitted to a facility. Preadmission notice must be obtained from the Claims Administrator.

Prescription Drug Out-of-Pocket Maximum (annual) The most You must pay toward the Allowed Amount for Prescription Drugs per Calendar year. After You reach the Out-of-Pocket Maximum, the Plan pays 100 percent of the Allowed Amount for Covered Services for the rest of the year. The Benefit Chart lists the Prescription Drug Out-of-Pocket Maximum amount.

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.

Primary Care Clinic or PCC A physician or group of physicians who have entered into an agreement with the Claims Administrator to provide or arrange for Covered Services.

Prior Authorization The Claims Administrator's approval for coverage of health services before they are provided.

Provider Any person, facility, or other program that provides Covered Services within the scope of the Provider's license, certification, registration, or training.

Qualified Life Event A change in your situation - like getting married, having a baby, or losing health coverage that can make you eligible for a Special Enrollment Period allowing you to enroll in health insurance outside the yearly Open Enrollment Period. You can find more detailed information regarding life events on the SEGIP website, mn.gov/mmb/segip

Referral Authorization in advance, in writing, by the Primary Care Clinic, which is limited in scope, duration and number of services.

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 Pharmacy Any licensed pharmacy that You can physically enter to obtain a Prescription Drug.

Semiprivate Room A room with more than one bed.

Skilled Care Services that are Medically Necessary and must be provided by registered nurses or other eligible Providers. A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of a licensed nurse. If a service, such as tracheotomy suctioning or ventilator monitoring or like services, can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (services which include skilled and non-skilled components) are covered under the Plan.

Social Security Disability Total disability as determined by Social Security.

Specialty Medication Drugs that are high-cost, high complexity and/or high touch. Specialty drugs are often biologic drugs derived from living cells that are injectable or infused (although some are oral medications). They are used to treat complex or rare chronic conditions such as cancer, rheumatoid arthritis, hemophilia, H.I.V., psoriasis, inflammatory bowel disease and hepatitis C. These drugs are on the specialty formulary and can change.

Specialty Pharmacy CVS Caremark has a Specialty Pharmacy network to provide certain specialty medications (e.g., injectable drugs for arthritis; growth hormones) to Members, with delivery directly to the Member's home.

Substance-Related Disorders Means addictive physical or emotional conditions or Illnesses caused by habitual use of alcohol or drugs.

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 and cotton balls, unless related to diabetes;
2. incontinence liners/pads;
3. Q-tips;
4. adhesives; and
5. 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.

Telemedicine The delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultation services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Terminally Ill Patient An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.

Treatment The management and care of a patient for the purpose of combating an Illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

You or Your The employee named on the identification (ID) card and any covered dependents.

XVI. 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:

a) reconstruction of the breast on which the mastectomy was performed;

b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c) 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.

XVII. Medical Data Privacy

Effective date: September 23, 2013
Reissue date: October 23, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Introduction

The State of Minnesota and other participating employers sponsor a Plan and are required by federal law to provide You this Notice of the Plan's privacy practices and related legal duties and of Your rights in connection with the use and disclosure of Your protected health information (PHI). Carefully review this Notice to understand your individual rights and the ways that the Plan protects your privacy.

PHI is defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations (the "Privacy Rule"). PHI generally means individually identifiable health information that is created or received by a covered entity, including the Plan, in any form or media, including electronic, paper and oral. Individually identifiable health information includes demographic data, that relates to an individual's past, present or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. For purposes of the Plan and this Notice, PHI includes information related to the medical claims that are submitted to the Plan about You, and information about the payment of those claims.

While this Notice is in effect, the Plan must follow the privacy practice described. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that applicable law permits such changes. The Plan also reserves the right to make such changes effective for all PHI that the Plan maintains, including information created or received before the changes were made.

This Notice applies to all PHI the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of Your medical information created in the doctor's office or clinic.

You may have additional rights under state law. State laws that provide greater privacy protection or broader privacy rights will continue to apply.

B. Health Plans covered by this Notice

This Notice describes the privacy practices of the group health plans listed here and together these plans are collectively referred to as the "Plan" for purposes of this Notice. Each of these plans is independent of one another. This Notice will apply to the extent that You participate in each separate plan. Minnesota Management and Budget / SEGIP contracts with internal and external entities to perform the work of each of these plans. In accordance with HIPAA, they may share PHI for the treatment, payment, and health care operations. Each entity is required to agree to additional terms and conditions to protect Your PHI.

Name of Plan	Plan Administrator	Claim Administrator
The Minnesota Advantage Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
The Advantage High Deductible Health Plan	SEGIP	BlueCross BlueShield of Minnesota, BlueCross BlueShield of Minnesota PPO HealthPartners, HealthPartners PPO PreferredOne pharmacy benefit claims through CVS Caremark
HealthPartners Dental Plan	SEGIP	HealthPartners
The State Dental Plan	SEGIP	Delta Dental
Flexible Benefits Accounts	SEGIP	121 Benefits LLC
Wellness Program	SEGIP	Virgin Pulse

C. The Plan's Rights and Obligations

1. The Plan is required by law to maintain the privacy of PHI.

2. The Plan is required by law to provide individuals with notice of the Plan's legal duties and privacy practices with respect to PHI.

3. The Plan is required to notify affected individuals of a breach of unsecured PHI.

4. The Plan is required to abide by the terms of the privacy practice described in this Notice. These privacy practices will remain in effect until the Plan replaces or modifies them.

5. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time, provided that the change is permitted by law. The Plan reserves the right to have such a change affect all PHI it maintains, including PHI it received or created before the change. When the Plan makes a material change in its privacy practices, it will revise this Notice and post it at mn.gov/mmb/segip by the effective date of the material change and the Plan will provide the revised Notice, or information about the material change and how to obtain the revised Notice, in the next annual mailing to participants.

D. Uses and Disclosures of Your Protected Health Information

To protect the privacy of Your PHI, the Plan not only guards the physical security of Your PHI, but also limits the way Your PHI is used or disclosed to others. The Plan may use or disclose Your PHI in certain permissible ways, including the uses and disclosures described below. To the extent required by HIPAA,

only the minimum amount of Your PHI necessary to perform these tasks will be used or disclosed. The following categories describe the different ways that the Plan uses and discloses your PHI. Not every use or disclosure within category is listed, but all uses and disclosures fall into one of the following categories.

1. **Your authorization**. Except as outlined below, the Plan will not use or disclose Your PHI unless You have signed a form authorizing the use or disclosure. You may give the Plan written authorization to use your PHI or to disclose it to anyone for any purpose. You have the right to revoke that authorization in writing and the Plan will stop using or disclosing Your PHI in accordance with that authorization except to the extent that the Plan has taken action in reliance upon the authorization. In addition, the Plan is required to obtain Your authorization under the following circumstances:

    a. Psychotherapy Notes. Most uses and disclosures of psychotherapy notes will require Your authorization.

    b. Marketing. Uses and disclosures of PHI which result in the Plan receiving financial payment from a third party whose product or services is being marketed will require Your authorization.

    c. Sale of PHI. Disclosures that constitute a sale of PHI will require Your authorization.

2. **Payment.** The Plan may use and disclose PHI about You for all activities that are included within the definition of “payment” under the Privacy Rule, such as determining Your eligibility for Plan benefits, the eligibility of Your dependents, facilitating payment for treatment and health care services You receive, determining benefit responsibility under The Plan, coordinating benefits with other Plans, or determining medical necessity. The Plan will also provide Your PHI to the extent necessary to provide required coverage for Your former spouse. The definition of “payment” includes many more items, so please refer to the Privacy Rule for a complete list.

3. **Health care operations**. The Plan may use and disclose PHI about You for health care operations. These uses and disclosures are necessary to operate the Plan. This may include developing quality improvement programs, conducting pilot projects, developing new programs, as well as cost management purposes. The definition of “health care operation” includes many more items, so please refer to the Privacy Rule for a complete list.

    The Plan will not sell your PHI. The Plan will not set Your premium or conduct underwriting for Your coverage using Your PHI. The Plan will not use Your genetic information for underwriting purposes. Plan members are required to verify the eligibility of their dependents.

4. **Treatment**. The Plan does not provide treatment. The Plan may use or disclose PHI for treatment purposes. This includes helping providers coordinate your healthcare. For example, a doctor may contact The Plan to ensure You have coverage or, in an emergency situation, to learn who are Your other providers or to contact Your family members if You are unable to provide this information.

5. **Disclosures to the Plan Sponsor (Your Employer)**. The State of Minnesota, or your participating employer, is the Plan Sponsor. The Plan may disclose Your PHI to them to the extent necessary to administer the Plan. These disclosures may be made only to designated personnel at the administrative units of the Employer, usually the benefits department or Your Human Resources department, and will be limited to the disclosures necessary for Plan administration functions. Generally, this will include enrollment and billing information. These individuals will protect the privacy of Your PHI and will ensure that it is only used as described in this Notice and as permitted by law. Your PHI will not be used by the Employer for any employment-related actions or decisions or in connection with any other benefit plan offered by the Employer.

6. **Sponsored health plan programs**. The Plan may use or disclose Your PHI to a HIPAA-covered health care provider, health plan, or health care clearinghouse, in connection with their treatment, payment, or health care operations.

7. **Communications about product, service and benefits**. The Plan may use and disclose Your PHI to tell You about possible medical treatment options, programs, or alternatives, or to tell You about health related products or services, including payment or coverage for such products or services, that may be of interest to You, provided the Plan does not receive financial remuneration for making such communications. The Plan may also use Your PHI to contact You with information about benefits under the Plan, including certain communications about Plan networks, health plan changes, and services or products specifically related to a health condition You may have. The Plan may use and disclose Your PHI to contact You to provide reminders, such as annual check-ups, or information about treatment alternatives or other health related benefits and services that may be of interest to You.

8. **Communications with individuals involved in Your treatment and/or Plan payment**. Although the Plan will generally communicate directly with You about Your claims and other Plan related matters that involve Your PHI, there may be instances when it is more appropriate to communicate about these matters with other individuals about Your health care or payment. This may include family, relatives, or close personal friends (or anyone else you may choose to designate).

   With Your authorization, the Plan may use or disclose Your PHI to a relative or other individual who You have identified as being involved in Your health care that is directly relevant to their involvement in these matters. If You are not present, the Plan's disclosure will be limited to the PHI that directly relates to the individual's involvement in Your health care. The Plan may also make such disclosures to these persons if: (i) You are given the opportunity to object to the disclosures and do not do so. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization; or (ii) if the Plan reasonably infers from the circumstances that You do not object to disclose to these persons, such as if You are not present or are unable to give Your permission and the Plan determines (based on its professional judgment) that the use or disclosure is in Your best interest. The Plan will not need Your written authorization to disclose Your PHI when, for example, You are attempting to resolve a claims dispute with the Plan and You orally inform the Plan that Your spouse will call the Plan for additional discussion relevant to these matters. The Plan may also provide limited PHI to Your former spouse to the extent reasonably required to continue Your former spouse on Your Plan, including information related to cost, payment, benefits, and the coverage of any joint children.

   The Plan may also use or disclose your name, location, and general condition (or death) to notify, or help to notify, persons involved in Your care about Your situation. If You are incapacitated or in an emergency, the Plan may disclose Your PHI to persons it reasonably believes to be involved in Your care (or payment) if it determines that the disclosure is in Your best interest.

9. **Research**. The Plan may use or disclose PHI for research purposes, provided that the researcher follows certain procedures to protect Your privacy. To the extent it is required by State law, The Plan will obtain Your consent for a disclosure for research purposes.

10. **De-Identified Data**. The Plan may create a collection of information that can no longer be traced back to You. This information does not contain individually identifying information.

11. **Business Associates**. The Plan may disclose Your PHI to a "business associate." The Plan's business associates are the individuals and entities the Plan engages to perform various duties on behalf of the Plan, or to provide services to the Plan. For example, the Plan's business associates might provide claims management services or utilization reviews. Business associates are permitted to receive, create, maintain, use, or disclose PHI, but only as provided in the Privacy Rule, and only after agreeing in writing to appropriately safeguard Your PHI pursuant to a business associate agreement.

12. **Other Uses and Disclosures**. The Plan may make certain other uses and disclosures of Your PHI without Your authorization:

a. The Plan may use or disclose Your PHI for any purpose required by federal, state, or local law. For example, The Plan may be required by law to use or disclose Your PHI to respond to a court order.

b. The Plan may disclose Your PHI in the course of a judicial or administrative proceeding (for example, to respond to a subpoena or discovery request.)

c. The Plan may use or disclose Your PHI for public health activities that are permitted or required by law, including reporting of disease, injury, birth and death, and for public health investigations.

d. The Plan may disclose Your PHI to a public or private organization authorized to assist in disaster relief efforts. The Plan may use or disclose Your PHI to help notify a relative or other individual who is responsible for Your health care, of your location, general condition, or death. In such situations, if You are present and able to give Your verbal permission, the Plan will only use or disclose Your PHI with Your permission. This verbal permission will only cover a single encounter, and is not a substitute for a written authorization. If You are not present or are unable to give Your permission, the Plan will use or disclose Your PHI only if it determines (based on its professional judgment) that the use or disclosure is in Your best interest.

e. The Plan may disclose Your PHI to a health oversight agency for activities authorized by law. The relevant agencies include governmental units that oversee or monitor the health care system, government benefit and regulatory programs, and compliance with civil rights laws. The relevant activities include conducting audits, investigations, or civil or criminal proceedings.

f. Under limited circumstances (such as required reporting laws or in response to a grand jury subpoena), the Plan may disclose Your PHI to the appropriate law enforcement officials for law enforcement purposes.

g. The Plan may disclose Your PHI to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties. If You are an organ donor, the Plan may disclose Your PHI to organ procurement or organ, eye, or tissue transplantation organizations, as necessary to facilitate organ or tissue donation and transplantation.

h. The Plan may use or disclose Your PHI to avert a serious threat to Your health or safety, or to the health and safety of others. Any such disclosure will be made to someone who would be able to help prevent the threat.

i. The Plan may disclose Your PHI, if You are in the Armed Forces, for activities deemed necessary by appropriate military command authorities, for determination of benefit eligibility by the Department of Veterans Affairs, or to foreign military authorities if You are a member of that foreign military service. The Plan may disclose Your PHI to authorized federal officials for conducting national security and intelligence activities (including for the provision of protective services to the President of the United States) or to the Department of State to make medical suitability determinations. If You are an inmate at a correctional institution, then under certain circumstances the Plan may disclose Your PHI to the correctional institution.

j. The Plan may disclose Your PHI to the extent necessary to comply with laws concerning workers' compensation or to comply with similar programs that are established by law and provide benefits for work-related injuries or illness.

k. The Plan may disclose Your PHI, consistent with applicable federal and state laws, if the Plan believes that You have been a victim of abuse, neglect, or domestic violence. Such disclosure will be made to the governmental entity or agency authorized to receive such information.

l. The Plan will disclose Your PHI to the Secretary of the Department of Health and Human Services, when required to do so, to enable the Secretary to investigate or determine the Plan's compliance with HIPAA and the Privacy Rule.

E. Your rights regarding Your Protected Health Information

You have the following rights relating to Your PHI:

1. **Right to access, inspect, and copy**. You have the right to look at or get copies of Your PHI maintained by the Plan that may be used to make decisions about Your Plan eligibility and benefits, with limited exceptions. The Plan may require You to make this request in writing to the Privacy Officer listed at the end of this Notice. Generally, the Plan will respond to Your request within 30 days after the Plan receives it; if more time is needed, the Plan will notify You within the original 30-day period. The Plan may deny Your request to inspect and copy in certain very limited circumstances. The Privacy Rule contains a few exceptions to Your right to inspect and copy Your PHI maintained by the Plan. You do not have the right to inspect or copy, among other things, psychotherapy notes or materials that are compiled in anticipation of litigation or similar proceedings. If Your written request is denied, You will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If the information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If we cannot agree on an electronic form and format, the Plan will provide You with a paper copy. You have a right to choose to receive a copy of all or of only portions of your PHI. The Plan may charge a fee for copying or mailing Your PHI for You but may waive that charge depending on Your circumstances. If you make a request in advance, the Plan will provide You with an estimate of the cost of copying or mailing the requested information.

2. **Right to request an amendment of Your PHI**. If You believe that there is a mistake or missing information in a record of Your PHI held by the Plan or one of its vendors, You may request in writing, that the record be corrected or supplemented. You have the right to request an amendment for as long as the PHI is kept by or for the Plan. Your request must be in writing and must include a reason or explanation that supports Your request. The Plan, or someone on its behalf, will respond usually within 60 days of receiving Your request. The Plan may deny the request if it is not in writing, it is determined that the PHI is correct and complete, not part of the PHI kept by or for the Plan, not created by the Plan or its vendors, and/or not part of the Plan's or vendor's records (unless the person or entity that created the information is no longer available to make the amendment), or not part of the information which You would be permitted to inspect and copy. All denials will be made in writing. Any denial will include the reasons for denial and explain Your rights to have the request and denial, along with any statement in response that You provide, appended to Your PHI. If the Plan denies Your request for an amendment, You may file a written statement of disagreement, which the Plan may rebut in writing. The denial, statement of disagreement, and rebuttal will be included in any future disclosures of the relevant PHI. If Your request for amendment is approved, the Plan or the vendor, will change the PHI and inform You of the change and inform others that need to know about the change. If the Plan approve Your request, the Plan will include the amendment in any future disclosures of the relevant PHI.

3. **Right to request and receive an accounting of disclosures**. You have a right to receive a list of routine and non-routine disclosures that Plan has made of Your PHI. This right includes a list of when, to whom, for what purpose and what portion of your PHI has been released by the Plan and its vendors. This does not include a list of disclosures for treatment, payment, health care operations, and certain other purposes (such as disclosures made for national security purposes,

to law enforcement officials, or correctional facilities). If the PHI disclosed is not an "electronic health record," the accounting will include disclosures for the six (6) years prior to the date of your request. In this case, as noted above, the accounting is not required to include all disclosures. If the PHI disclosed is an "electronic health record," the accounting will include disclosures up to three (3) years before the date of Your request. Your request for the accounting must be made in writing. Your request must include the time frame that You would like the Plan to cover (this may be no more than six (6) years before the date of the request). You will normally receive a response to Your written disclosure for this accounting within 60 days after your request is received. There will be no charge for up to one such list each year but there may be a charge for more frequent requests. The Plan will notify You of the cost involved and You may choose to withdraw or modify Your request at that time before any costs are incurred.

4. **Right to request restrictions**. You have the right to request that the Plan restrict how it uses or discloses Your PHI for treatment, payment, or health care operations. You also have the right to request a limit on the PHI about You that the Plan discloses to someone who is involved in Your care or the payment of Your care, like a family member or friend. The Plan will consider Your request but generally is not legally bound to agree to the request for restriction. However, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which You, or another person on Your behalf, has paid the health care provider or other covered entity involved in full. Your request must be in writing. In Your request, You must tell the Plan (1) what information You want to limit; (2) whether You want to limit the Plan's use, disclosure, or both; and (3) to whom You want the limits to apply, for example, disclosure to Your spouse. If the Plan does agree to Your restriction it must comply with the agreed to restriction, except for purposes of treating You in an medical emergency.

5. **Right to choose how the Plan contacts You**. You have the right to request that the Plan communicate with You about Your PHI by alternative means or to an alternative location. For example, you may request that the Plan only contact you at designated address or phone number. Your request must be in writing. In Your request, You must tell us how or where You wish to be contacted. The Plan will make a reasonable accommodation of Your request for confidential communication.

6. **Right to request a copy of this Notice in an alternative format**. You are entitled to receive a printed copy of this Notice at any time as well as a non-English translation. You may ask the Plan to give You a paper or electronic copy of this Notice at any time. Even if You have agreed to receive this Notice electronically, You are still entitled to a paper copy of this Notice. Contact the Plan using the information listed at the end of this Notice to obtain an alternative copy of this Notice.

F. Complaints

If You believe Your privacy rights have been violated, You may file a complaint with the Plan, or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, send a written complaint to the Privacy Officer listed at the end of this Notice. The Plan will not retaliate against You for filing a complaint, and You will not be penalized in any other way for filing a complaint.

G. Contact Information for questions

If You have questions about this Notice or would like more information about the Plan's privacy practices, please contact:

Privacy Officer
Minnesota Management and Budget / SEGIP
400 Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
(651) 355-0100
segip.mmb@state.mn.us

Minnesota Management and Budget

NOTICE OF COLLECTION OF PRIVATE DATA
(September 2, 2017)

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). This notice explains why we are requesting the private data about You, Your spouse, and dependents, how we will use it, who will see it, Your obligation to provide the data, and the result of providing or not providing the requested data.

What data will we use?

We will use the data You provide us at this time, as well as data previously provided us, about You, Your spouse, and dependents. If You provide any data that is not necessary, we will not use it for any purpose.

Why we ask You for this data?

We ask for this data so that we can successfully administer employee group health benefits that are self-insured. This data is used to process Your request to add, change, or drop coverage for Yourself and Your spouse or dependents. The requested data also helps us to determine eligibility, to identify, and to contact You and Your spouse and dependents. The data is used to administer programs, develop new programs, to determine if programs are properly managed and meet member needs, and to comply with federal and state laws and rules.

Do You have to answer the questions we ask?

You are not required to provide any of the data but certain data must be collected or we may be unable to administer the programs or provide You Your benefits.

What will happen if You do not answer the questions we ask?

If You do not provide the requested data, You or Your spouse and dependent may not be approved to participate in a program or may lose coverage under the program or the participation may be delayed.

Who else may see this data about You and Your spouse and dependents?

We may give data about You, Your spouse and dependents to the group health benefits that are self-insured and service providers You have chosen, as well as SEGIP's other contracted vendors, so that they may help administer the programs. We may also provide this data to the Legislative Auditor; the Department of Health; the Department of Commerce; and any law enforcement agency or other agency with the legal authority to have the data; and anyone authorized by a court order. In addition, the parents of a minor may see data on the minor unless there is a law, rule, court order, or other legally binding instrument that blocks the parent from that data.

How else may this data be used?

We can use or release this data only as stated in this notice or allowed under law unless You give us Your written permission to release the data for another purpose or to release it to another individual or entity. The data may also be used for another purpose if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the data or to use it for another purpose.

XVIII Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If You are eligible for health coverage through SEGIP, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If You or Your dependents are already enrolled in Medicaid or CHIP and You live in Minnesota, contact the Minnesota Medicaid office to find out if premium assistance is available. The telephone number is 800/657-3739; You may also go to https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/families.jspIf You live in another state, dial 1-877-KIDS NOW or go to the Insure Kids Now Website at www.insurekidsnow.gov.

If You or Your dependents are NOT currently enrolled in Medicaid or CHIP, and You think You or any of Your dependents might be eligible for either of these programs, You can contact Your State Medicaid or CHIP office, or dial 1-877-KIDS NOW or access the Insure Kids Now Website to find out how to apply. If You qualify, You can ask if there is a program that might help You pay the premiums for the SEGIP Plan.

Once it is determined that You or Your dependents are eligible for premium assistance under Medicaid or CHIP, SEGIP is required to permit You and Your dependents to enroll in the Plan – as long as You and Your dependents are eligible, but not already enrolled in the SEGIP Plan. This is called a "special enrollment" opportunity, and You must request coverage within 60 days of being determined eligible for premium assistance. You must also notify SEGIP within 60 days if Your coverage or Your dependent's coverage terminates under Medicaid or CHIP due to loss of eligibility.

For more information, contact:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Minnesota
mn.gov/dhs
Click on https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/families
Phone: 651-431-2670
1-800-657-3739

Wisconsin
https://www.dhs.wisconsin.gov/badgercareplus/index.htm
Phone: 1-800-362-3002

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Iowa
www.dhs.state.ia.us/hipp
Phone: 1-888-346-9562

North Dakota
http://www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-800-755-260

Upon request, this guide can be made available in alternative formats such as Braille, large print or audio tape.