Summary of Benefits 2009-2010

Your health care coverage through the
Minnesota Public Employees Insurance Program

PEIP Advantage Health Plan

PEIP
Minnesota Public Employees Insurance Program

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.

Name of Urgent Care Facility used by your PCC: _____

Address: _____

Phone: _____

Please also refer to Section IV.L, page 26, for information regarding services provided to Advantage members by convenience clinics.

To Participants in the Public Employees Insurance Program Advantage Health Plan:

Your Summary of Benefits is an important reference booklet that provides a detailed description of the medical coverage available to you through the Minnesota PEIP Advantage Health Plan ("Advantage"). It also provides information on the levels of cost-sharing that are in effect for the plan year. Finally, this booklet 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.

Please take a few minutes to fill in the information on the previous page 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 at the time of your enrollment at one of the following numbers. Also included is the number for Navitus, the plan's pharmacy benefit manager.

Blue Cross and Blue Shield	651.662.9930 or 866.286.2948
HealthPartners	952.883.5000 or 800.883.2177
PreferredOne	763.847.4477 or 800.997.1750
Navitus Health Solutions	866.333.2757

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan 2009-2010 Benefits Schedule

2009-2010 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)	$50/100	$140/280	$350/700	$600/1,200
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care within the service area ● Outpatient visits in a physician's office ● Chiropractic services ● Outpatient mental health and chemical dependency	$17 copay per visit annual deductible applies	$22 copay per visit annual deductible applies	$27 copay per visit annual deductible applies	$37 copay per visit annual deductible applies
D. Convenience Clinics	$10 copay	$10 copay	$10 copay	$10 copay
E. Emergency (in service area) ● Emergency care received in a hospital emergency room	$75 copay annual deductible applies	$75 copay annual deductible applies	$75 copay annual deductible applies	25% coinsurance annual deductible applies
F. Inpatient Hospital Copay	$85 copay annual deductible applies	$180 copay annual deductible applies	$450 copay annual deductible applies	25% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$55 copay annual deductible applies	$110 copay annual deductible applies	$220 copay annual deductible applies	30% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics and Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	30% 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)	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	10% coinsurance annual deductible applies	30% coinsurance annual deductible applies
K. MRI/CT Scans	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	10% 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	10% coinsurance annual deductible applies	30% 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.	$10 tier one $16 tier two $36 tier three	$10 tier one $16 tier two $36 tier three	$10 tier one $16 tier two $36 tier three	$10 tier one $16 tier two $36 tier three
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excluding PKU, Infertility, growth hormones)(single/family)	$800/1,600	$800/1,600	$800/1,600	$800/1,600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs)(single/family)	$1,100/2,200	$1,100/2,200	$1,100/2,200	$1,100/2,200

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network: the plan covers 80% of the first $2,000 of eligible charges, then 100% per calendar year.

Out-of-Network coverage available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area. The members pay a $350 single or $700 family deductible and 30% coinsurance to the out-of-pocket maximums 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.

A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits are administered, and in the referral and diagnosis coding patterns of primary care clinics.

Introduction

This Summary of Benefits is intended to describe your medical coverage under the PEIP Advantage Health Plan (the "Plan"). Your employer sponsors the Plan. This Plan is offered and made available through the Minnesota Public Employees Insurance Program ('PEIP'). The Claims Administrator administers all claims. 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, and your rights to convert coverage to an individual policy under certain circumstances. You will also find a description of the medical 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 and co-payments 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 that administer the Plan: Blue Cross Blue Shield of Minnesota (BCBSM), HealthPartners and PreferredOne. At enrollment time each year you have the opportunity to select the benefit arrangement and the company administering benefits you want to use for the year.

For further information you may contact your employer or the Claims Administrator you have selected at the appropriate address below:

BLUE CROSS BLUE SHIELD

Blue Cross Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560
651.662.9930
866.286.2948
TTY 651.662.8700
888.878.0137

HEALTHPARTNERS

HealthPartners Administrators, Inc.
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
952.883.5000
800.883.2177
TDD 952.883.5127

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

NAVITUS HEALTH SOLUTIONS

P.O.Box 999
5 Innovation Court, Suite B
Appleton, WI 54912-0999
866.333.2757
TTY 920.225.7005

Specific information about the plan

Name of the Plan: The Plan shall be known as the Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan which provides medical benefits to certain eligible participants and their dependents.

Address of the Plan:
Minnesota Management & Budget
Public Employees Insurance Program
400 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Plan Year: The plan year begins with the date designated by the Plan Sponsor.

Plan Sponsor: Your employer sponsors its employee benefit plan

Agent for Service of Legal Process:
PEIP Manager
Minnesota Management & Budget
Public Employees Insurance Program
400 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Funding: Claims under the Plan are paid from the assets of a trust established through a combination of contributions from you, your employer and PEIP.

Claims Administrators:

BLUE CROSS BLUE SHIELD

Blue Cross Blue Shield of Minnesota
P.O. Box 64560
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Table of contents

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 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 XI).

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

Your employer ("Sponsor") has established a Group Health Plan ("the Plan") to provide medical benefits for covered contract holders and their covered dependents ("Members"). The Plan is a 'self-funded' medical plan. Benefits are provided jointly by your employer and PEIP and are funded through a combination of contributions from you, your employer and PEIP. The Plan is described in this Summary of Benefits ("SB"). The Plan has contracted with BCBSM, HealthPartners and PreferredOne to provide networks of health care providers, claims processing, pre-certification and other administrative services. However, PEIP is solely responsible for payment of your eligible claims.

PEIP reserves the right to change or terminate the Plan. This includes, but is not limited to, 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.

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 Administrator. 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 ("the 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. 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 ID card from Navitus Health Solutions, which must be used when receiving pharmacy services.

You must show your ID card every time you request health care 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.

D. Provider Directory

A provider directory is available through the PEIP/MMB website (www.mmb.state.mn.us) that lists 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..

E. 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.

F. 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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. (See also Section XVI, Medical Data Privacy.)

G. 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 PEIP Advantage Health Plan ("Advantage")

Each contract holder participating in the PEIP 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 change to clinics in different Cost Levels during the annual open enrollment and may also elect to move to a clinic in a different Cost Level within the same Claims Administrator up to two additional times during the plan year. Members may elect to change clinics within the same Cost Level as often as the Claims Administrator permits. PCC changes must be received by the 20th of the month for PreferredOne to be effective for the first of the following month. For BCBSM, changes can be received any time during the month to be effective the first of the following month. HealthPartners allows clinic changes to be made anytime during the month, but only one change per 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 – HH. 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 plan 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.

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

You do have the option of self-referring to an OB/GYN, mental health, chemical health, vision care or chiropractor who participates in the network associated with your PCC of the Claims Administrator you have selected. Please refer to your provider directory. Providers in such self-referral networks do not have referral authority.

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 PCC's care network without a referral. Please call HealthPartners for further information.) Providers to whom you are referred do not have further referral authority.

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.

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, require approval prior to the service.

d) Charges That Are Your Responsibility

When you use your PCC you are responsible for:

i) Copays;
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.1.h, and IV.FF, 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) 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 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 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 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.

g) 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 network urgent care or primary care facilities without contacting your own PCC. (Please note that HealthPartners members must use urgent care facilities for these needs; if a network urgent care facility is not used, the services received will be treated as out-of-network emergency care.)

All members, including dependent students away at school, may receive urgent care while away from home, but for routine care please see Section V. A, Authorized Care Outside the Service Area.

h) 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.
- The Permanent Residence of the employee is considered to be the Permanent Residence for all dependents in his/her family.

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 PEIP 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 PEIP 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 PEIP 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), spouses, and ex-spouses living out of area. The benefit schedule includes a $350 single/$700 family deductible and 30% coinsurance. 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.) College students attending school out of the area are covered under the POS benefit while out-of-area; when in-area, they are covered through the PCC at the cost level they have chosen.

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 PPO 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 PEIP 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 deductible, 30% coinsurance).

Employees traveling out of the service area will receive the out-of-area emergency and urgent care benefit: 80% coverage of the first $2000, then 100% coverage. Employees traveling out of state may receive provider discounts when using the National PPO of the Claims Administrator with whom they are enrolled.

B. COVERAGE ELIGIBILITY AND ENROLLMENT

1. Eligibility

Your eligibility for coverage is determined by your employer. Retirees and their dependents not yet eligible for Medicare may participate in the Plan, provided that the employer from which they retired offers coverage under the Public Employees Insurance Program (in agreement with Minnesota Statute §471.61).

Employees covered under a collective bargaining agreement are eligible only if the agreement specifies coverage under this Plan.

The Claims Administrator agrees to accept the decisions of the Public Employees Insurance Program as binding. If two or more employees having mutual dependents participate in the Public Employees Insurance Program (PEIP), only one of the employees may cover their mutual dependents.

Eligible dependents include the following:

a) An employee's spouse (if not legally separated). If both spouses work for the same employer or another employer that participates in PEIP, then neither employee may be covered as a dependent of the other, unless one spouse is not eligible for coverage.

b) An employee's unmarried dependent child from birth to age 25. A dependent child includes an employee's own child, a legally adopted child or child placed for the purposes of adoption, a foster child, or a step-child. To be considered a dependent child, a foster child must be dependent on the employee for his/her principal support and maintenance, and must be placed by the court in the custody of the employee. To be considered a dependent child, a step-child must be dependent on the employee for his/her principal support and maintenance, and must maintain residence with the employee.

Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.

An employee's unmarried dependent grandchild is also an eligible dependent if the grandchild is (1) placed in the legal custody of the employee, (2) legally adopted by the employee or placed with the employee for the purpose of adoption, or (3) the dependent child of an employee's unmarried dependent child. Under (1) and (3) above, the grandchild must be dependent upon the employee for principal support and maintenance and live with the employee.

c) An employee's dependent child of any age or marital status, or the employee's spouse, if she/he is incapable of self-sustaining employment by reason of mental retardation, mental illness or physical disability and is chiefly dependent upon the employee for her/his support and maintenance. If the dependent is 25 years of age or older at the time of the employee's enrollment or initial employment, then the employee must provide the Claims Administrator with proof that the dependent meets these requirements within 31 days of the initial date of employment or enrollment.

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The handicapped dependent shall be eligible for coverage as long as he or she continues to be handicapped and dependent, unless coverage otherwise terminates under the Plan.

d) Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order.

e) Any person who is an eligible dependent under the employee's bargaining agreement or plan of employment.

2. 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 made within 31 days of the date you first become eligible. 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.

3. Effective Date of Coverage

Unless your employer has established its own effective date rules, the initial effective date of coverage is the first of the month following 30 calendar days after the first day of employment. The initial effective date of coverage for an employee whose eligibility has changed is the date of the change. 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 you and your dependents apply for coverage during an open enrollment period, coverage will become effective on the date specified by the Public Employees Insurance Program.

Adopted children are covered from the date of placement for the purposes of adoption, and handicapped dependents are covered from your effective date of coverage even though they are hospitalized on the effective date of coverage.

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

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

4. Off-Cycle Enrollment

You and your dependents will be allowed to make an enrollment choice outside of the annual enrollment period or initial period of eligibility within 30 calendar days of the events specified below.

a) Any Claims Administrator participating in the PEIP is placed into reorganization or liquidation, or is otherwise unable to provide the services specified in the Summary of Benefits.

b) Any Claims Administrator participating in the PEIP loses all or a portion of its primary care provider network (including Hospitals) to the extent that services are not accessible or available within 30 miles of the work station, including withdrawal from an approved service area.

c) Any Claims Administrator participating in the PEIP terminates or is terminated from participation in the Program.

d) The PEIP approves a request from an employee or employer due to a breakdown in the open enrollment process, such as a systems error or errors in the transmission of information.

e) An employee is transferred to a location where his or her Claims Administrator is not operating. In addition, an employee who receives notification of a work location change between the end of an Open Enrollment period and the beginning of the next insurance year may change his/her health plan within 30 days of the date of relocation under the same provisions accorded during the last open enrollment period.

f) You may add coverage for all eligible dependents after the following events:

i) You marry

ii) If your dependent spouse loses group coverage, the employee may add dependent coverage. Loss of coverage includes any involuntary changes in coverage which result in termination of your dependent's coverage, regardless of whether it is immediately replaced by other subsidized coverage. Loss of coverage does not include the following:

(a) A change in Claims Administrators through the same employer where the coverage is continuous and uninterrupted;

(b) A change in your dependent's health plan benefit levels; and

(c) A voluntary termination by your dependent, including, but not limited to termination or reduction of coverage due to the adoption of cafeteria-style plans.

You must provide a written request to the PEIP requesting dependent coverage in order to be eligible under this provision. The written request must be accompanied by a statement from the group Third Party Administrator documenting the loss of coverage.

g) When you acquire your first dependent child

In addition, the spouse and dependents may be added to coverage at this time.

h) Retirees may elect to designate another Claims Administrator in the 60 days immediately preceding the effective date of retirement.

i) As otherwise specified by the PEIP.

5. Special Enrollment Period

If you are eligible, but not enrolled for coverage under the Plan, or if your dependent is eligible but not enrolled for coverage under the Plan, you or your dependent may enroll for coverage under the terms of the Plan if all of the following conditions are met:

a) You were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your dependent;

b) You stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Sponsor required such a statement at such time and provided you with notice of such requirement and the consequences of such requirement at such time;

c) Your coverage or your dependent's coverage described in a. above was:

i) under a COBRA continuation provision and the coverage under such provision was exhausted; or

ii) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and

d) You requested such enrollment not later than 30 days after the date of exhaustion of coverage described in c(i) above, or termination of coverage or employer contribution described in c(ii) above.

Dependent beneficiaries may enroll if: (a) a group health plan makes coverage available with respect to a dependent of an employee; (b) the employee is covered under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for failure to enroll during a

previous enrollment period); and (c) a person becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption. The Plan shall provide for a dependent special enrollment period during which the person (or, if not otherwise enrolled, the employee) may be enrolled under the Plan as a dependent of the employee and in the case of birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. A dependent special enrollment period shall be a period of not less than 30 days and shall begin on the later of :

a) The date dependent coverage is made available; or
b) The date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If you seek to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

a) In the case of marriage, as of the date of such marriage;
b) In the case of a dependent's birth, as of the date of such birth; or
c) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

6. Late Enrollment

If you are a late entrant, you may enroll yourself and any eligible dependents:

a) During the annual Open Enrollment period; or
b) At any time, if you or your dependents have maintained continuous and qualifying coverage within 63 days prior to your application for coverage under the Plan; or
c) During a special enrollment period.

7. Open Enrollment

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

8. 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, 3 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, but if you have single coverage in effect you must fill out an application for family coverage within 30 days of the date of the marriage.

b) Adding newborns

If you have single or family coverage in force, 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. If you have single coverage in force, coverage for the child will become effective on the date of birth, once you have applied for family coverage.

c) Adding children placed for adoption

i) If you have single coverage in force under the Plan, coverage for such child will take place on the date of placement, once you have applied for family coverage.

ii) If you have family coverage in force under the Plan, coverage for such child will take effect on the date of placement. Failure to submit an application for the child will not alter the effective date of coverage, but will result in claims services 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.

9. 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 or converted in some instances as specified in Continuation of Coverage and Conversion (see Section III, B,12).

a) For you and your dependents, the date that either the Claims Administrator or your employer 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.

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, the last day of the month following the receipt of a written request by you to cancel coverage.

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.

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, the last day of the month for which the last full premium was paid, when the enrollee fails to pay the premium within 31 days of the date the premium was billed or due, whichever is later.

If the Plan Sponsor erroneously enrolled an employee or a dependent, and subsequently requests coverage termination retroactively to the effective date of the coverage, coverage will remain in force to a current paid-to-date, unless the Plan Sponsor obtains the written consent from the employee or dependent authorizing retroactive termination of coverage.

10. Certificate of Health Plan Coverage

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

The certification of health plan coverage form will be issued to you when you terminate coverage with the group, and, if applicable, at the expiration of any continuation period. The Claims Administrator will also issue the form if you request an additional copy at any time within the 24 months after your coverage terminates.

11. 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.

12. Continuation and Conversion

You have the right to temporary extension of coverage under the Public Employees Insurance Program (the Plan). The right to continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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. This notice gives only a summary of your continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact the Third Party Administrator.

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% administration fee based on the cost of your premium from the date of coverage would have terminated.

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 or legally separated 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 Third Party 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 Third Party Adminis-

trator 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 or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Third Party Administrator in writing. The Plan requires you to notify the Third Party Administrator within 60 days after the qualifying event occurs. You must send this notice to: the Minnesota PEIP, Innovo Benefits, 8220 Commonwealth Drive, #150, Eden Prairie, MN 55344. Failure to provide notice may result in the loss of your ability to elect continuation coverage.

How is continuation coverage provided?

Once the Third Party Administrator receives 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 months.
- When the qualifying event is the death of the employee or divorce or legal separation, 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 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 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 your family 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 make sure that the Third Party Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: the Minnesota PEIP, Innovo Benefits, 8220 Commonwealth Drive, #150, Eden Prairie, MN 55344..

Special rule for preexisting condition continuation

If you or your covered dependents obtain other group coverage that excludes benefits for preexisting conditions, you or your covered dependents may choose to remain on continuation for a preexisting condition until the date continuation would otherwise end or until the preexisting clause of the new plan is met, whichever occurs first. This Plan is primary and determines benefits first for the preexisting condition. This Plan is not primary for any other condition. For a newborn

child born during continuation, the other plan is primary starting on the date of birth.

Conversion

You must exhaust your continuation of coverage before conversion is available. You or your dependents may convert your coverage to an individual qualified plan if coverage ends because:

i) You or your dependents become ineligible under this Plan or leave the Plan for any reason;

ii) You or your dependents exhaust the maximum period of continuation coverage available to you as described in the "Continuation of Coverage" section of this Plan; or

iii) The Plan ends and is not replaced by continuous group coverage within 63 days.

If your coverage ends because you become ineligible, leave the group, or you exhaust your continuation rights, you must apply for conversion coverage within 63 days after your coverage or continuation ends.

If your coverage ends because the Plan ends, you must apply for conversion coverage within 63 days after receiving notice of cancellation of the Plan.

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 Third Party 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 Third Party 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 PEIP, Innovo Benefits, 8220 Commonwealth Drive, #150, Eden Prairie, MN 55344.

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 employer's Human Resources office or the Third Party Administrator to become informed about those rules.

If you have questions

If you have questions about your continuation of coverage, you should contact the Third Party Administrator, 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 Your Plan Informed of Address Changes

In order to protect your rights and those of your qualified dependents, you should keep the Third Party Administrator 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 Third Party Administrator.

Conversion coverage and charges will not be the same as the Plan. Evidence of good health is not required. Regardless of the reason coverage ends, you are not eligible for conversion if you are covered under another qualified plan, you do not make timely application, or your coverage ends because of failure to pay required charges when due. Conversion coverage will not contain any preexisting condition limitation or other limitations and exclusions that have not been satisfied under this Plan.

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 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 Third Party 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% 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 866.628.4282.

13. 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.

14. Retirement

An employee who is retiring from any employer that is eligible to participate in the PEIP and who is eligible to maintain participation in the PEIP as determined by PEIP may, consistent with state law, indefinitely maintain health coverage with the PEIP by filling out the proper forms 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 12 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 PEIP.

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	$17	$22	$27	$37
B. Emergency room Copayment	$75	$75	$75	25% coinsurance
C. Annual Deductible	Single: $50 Family: $100	Single: $140 Family: $280	Single: $350 Family: $700	Single: $600 Family: $1200
D. Coinsurance after annual Deductible for services not subject to Copayment	5%	5%	10%	30%
E. Coinsurance for Durable Medical Equipment	20%	20%	20%	30% Annual deductible applies
F. Prescription Drug Out-of-Pocket Maximum per year	Single: $800 Family: $1600	Single: $800 Family: $1600	Single: $800 Family: $1600	Single: $800 Family: $1600
G. Out-of-Pocket Maximum for services other than Prescription Drugs per year	Single: $1100 Family: $2200	Single: $1100 Family: $2200	Single: $1100 Family: $2200	Single: $1100 Family: $2200
H. Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

Notes:

- 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, durable medical equipment, hospice, maternity, and ventilator dependent communication services, are subject to an annual deductible.
- 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.
- The 20% coinsurance for diabetic supplies is your responsibility, and does accumulate toward the Prescription Drug Out-of-Pocket Maximum.
- The highest cost level in which any family member incurs expenses determines the amount of the family annual deductible 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 deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.
- For the situation where two employees covered by the PEIP Advantage Health Plan 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 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
I. Ambulance				
The Plan covers: • Ground ambulance to the nearest facility qualified to treat the Illness • Air ambulance from the place of departure to the nearest facility qualified to treat the Illness • 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. 10% coinsurance	Annual deductible applies. 30% 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. This restriction does not apply to HealthPartners members.
- 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
J. Chemical Health Care				
The Plan covers:				
• Medically Necessary outpatient professional services for diagnosis and treatment of Substance-Related Disorders rendered in an office.	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay 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. 10% coinsurance	Annual deductible applies. 30% 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. $85 copay per admission	Annual deductible applies. $180 copay per admission	Annual deductible applies. $450 copay per admission	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 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 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.
- 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. 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).

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 Secion.

Benefit Feature	You Pay Cost Level 1	You Pay Cost Level 2	You Pay Cost Level 3	You Pay Cost Level 4
K. CHIROPRACTIC CARE				
The Plan covers:				
• Chiropractic care rendered to diagnose and treat acute neuromuscular-skeletal conditions	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay 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.
- Massage therapy which is performed in conjunction with other treatments/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered.

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).

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
L. Covenience Clinics				
The Plan covers:				
• Care received at convenience clinics/retail health clinics	$10 copayment. Annual deductible applies	$10 copayment Annual deductible applies	$10 copayment Annual deductible applies	$10 copayment Annual deductible applies

Notes:

- Members must use a convenience clinic/retail health clinic 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 $10 per visit, which is waived for preventive care (including vaccinations and some screenings). The first dollar deductible is also waived and copayments are credited to the out-of-pocket maximum. No appointments are necessary. Individuals with illnesses outside the scope of services or who exhibit signs of a chronic condition will be referred to to their physician or, if critical, the nearest urgent care center or emergency room. Patients who can't be treated are not charged for their visit.

Benefit Feature
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	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 dedictible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% coinsurance
Outpatient surgical services rendered in a hospital or surgical facility	Annual deductible applies. $55 copay	Annual deductible applies. $110 copay	Annual deductible applies. $220 copay	Annual deductible applies. 30% coinsurance
Inpatient hospital dental services	Annual deductible applies. $85 copay	Annual deductible applies. $180 copay	Annual deductible applies. $450 copay	Annual deductible applies. 25% coinsurance
Care rendered in an office setting	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 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 twelve (12) months after the date of the injury. For HealthPartners members, treatment must begin within twelve (12) months 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
N. Emergency and Urgent Care				
If you use your PCC or provider within the network the Plan covers:				
• Emergency care/urgent care in a physician's office or a network urgent care center.	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• Emergency care/urgent care in a Hospital emergency room.	Annual deductible applies. $75 copay per visit	Annual deductible applies. $75 copay per visit	Annual deductible applies. $75 copay per visit	Annual deductible applies. 25% coinsurance
• Emergency dental care in an outpatient Hospital or emergency room.	Annual deductible applies. $75 copay per visit	Annual deductible applies. $75 copay per visit	Annual deductible applies. $75 copay per visit	Annual deductible applies. 25% coinsurance
• Emergency dental care through the dental network for HealthPartners members	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• Enhanced radiology services	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% coinsurance
If you use out-of-network or out of area providers you pay:				
• Emergency care/urgent care in a physician's office or urgent care center.	You pay 20% of Allowed Amount of the first $2000 of eligible charges per year.			
• Emergency care/urgent care in a Hospital emergency room.	You pay 20% of Allowed Amount of the first $2000 of eligible charges per year.			
• Emergency dental care in an outpatient Hospital or emergency room.	You pay 20% of Allowed Amount of the first $2000 of eligible charges per year.			
	See page 73 for the definition of Allowed Amount.			

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 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 network urgent care or primary care facilities without contacting your own Primary Care Clinic. (Please note that HealthPartners members must use network urgent care facilities for these needs; if a network urgent care facility is not used, the services used will be treated as out-of-network emergency care.)

All members, including dependent students away at school, 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
O. Habilitative and Rehabilitative Therapy Services				
The Plan covers: • Rehabilitative or habilitative physical, speech and occupational therapy services received in a clinic, office or as an outpatient • 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. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
P. Home Health Care				
The Plan covers medically necessary rehabilitative or terminal: • Care ordered in writing by a physician • Care provided by a Medicare certified Home Health Agency • Skilled Care must be provided by the following Home Health Agency employees: – registered nurse – licensed registered physical therapist – registered occupational therapist – certified speech and language pathologist – respiratory therapist – medical technologist – registered dietician • Services of a home health aide or social worker employed by the Home Health Agency when provided in conjunction with services provided by the above listed agency employees • Home Health Care following early Maternity Discharge, Section IV.W. or IV.P.	Annual deductible applies. 5% coinsurance Nothing	Annual deductible applies. 5% coinsurance Nothing	Annual deductible applies. 10% coinsurance Nothing	Annual deductible applies. 30% coinsurance Nothing

NOTES:

- Benefits for Prescription Drugs used during home health care are listed under Prescription Drugs, Section IV.BB.
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy, Section IV.Q.
- 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Q. Home Infusion Therapy				
The Plan covers Medically Necessary • Home infusion therapy services when ordered by a physician and provided by a participating Medicare certified home infusion therapy provider associated with your PCC • Solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Durable medical equipment • Ancillary medical supplies • Nursing services to: – train you or your caregiver, or – monitor the home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
R. Hospice Care				
The Plan covers: • Hospice care for the terminally ill patients provided by a Medicare-certified hospital provider or other preapproved hospice. • Inpatient and outpatient hospice care and other supportive services provided to meet the physical, psychological, spiritual, and social needs of the dying individual • 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 • 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
S. Inpatient Hospital				
The Plan covers: • 365 (366) days per Calendar Year for Semiprivate Room and board and general nursing care. Private room is covered only when Medically Necessary • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription Drugs and supplies used during a covered hospital admission • Lab and diagnostic imaging • Enhanced radiology services, including CT scans and MRIs • Physical, occupational, radiation and speech therapy • 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 • General nursing care • Physician and other professional medical services provided while in the hospital • Emergency care	Annual deductible applies. $85 copay per inpatient admission	Annual deductible applies. $180 copay per inpatient	Annual deductible applies. $450 copay per inpatient admission	Annual deductible applies. 25% coinsurance
	Nothing	Nothing	Nothing	
	See Section IV.N. Emergency and Urgent Care.			

NOTE:

- 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.
- For inpatient maternity admissions, one copayment will be assessed unless the baby remains in the hospital after the mother is discharged, at which point an additional copayment will be assessed.

NOT COVERED:

- Please refer to the Exclusions section.

Benefit Features	In-Network Provider	
T. Organ and Bone Marrow Transplant Coverage for Blue Cross Blue Shield Members		
The Plan covers:	Participating:	Non-Participating Transplant Providers

The following medically necessary human organ and bone marrow transplant and peripheral stem cell support procedures:
• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell support procedures
• Autologous bone marrow transplant and peripheral stem cell support procedures
• Heart, heart-lung, liver (cadaver and living), lung (single or double)
• Small-bowel or small-bowel/liver
• Pancreas transplant
  • Cadaver – eligible as pancreas transplantation alone (PTA), simultaneous pancreas and kidney transplantation (SPK), or pancreas transplantation after kidney transplantation (PAK), or
  • Living donor segmental pancreas transplantation – eligible alone, at the time of, or following kidney transplantation
	Blue Quality Centers for Transplant (BQCT) Providers
	100% of the Transplant Payment Allowance for the transplant admission, subject to the benefit allowance.
	If you live more than 50 miles from a BQCT Provider, there may be benefits available for travel, meals and lodging expenses directly related to a preauthorized transplant. For more information contact the Transplant Coordinator at the number listed below.
	For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
	Non-Blue Quality Centers for Transplant (BQCT)
	ProvidersParticipating Transplant Provider-
	100% of the Transplant Payment Allowance. for the Transplant admission, subject to the benefit chart on page 2.
		Non-Blue Quality Centers for Transplant (BQCT) Providers
		NO COVERAGE
		For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.

NOTES:

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

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

If you have specific questions on Organ and Bone Marrow Transplant Coverage, call the Transplant Coordinator of Blue Cross and Blue Shield of Minnesota, Monday through Friday, from 8:00 a.m. to 4:30 p.m. (Central Time) at 651.662.1624 or 888.878.0139, extension 21624.

T. Organ and Bone Marrow Transplant Coverage for Blue Cross Blue Shield Members (Continued)

NOT COVERED:

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

DEFINITIONS:

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

	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. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• In an outpatient hospital or surgical facility	Annual deductible applies. $55 copay per visit	Annual deductible applies. $110 copay per visit	Annual deductible applies. $220 copay per visit	Annual deductible applies. 30% coinsurance
• In an inpatient hospital setting	Annual deductible applies. $85 copay per visit	Annual deductible applies. $180 copay per visit	Annual deductible applies. $450 copay per visit	Annual deductible applies. 25% coinsurance

U. Organ and Bone Marrow Transplant Coverage for HealthPartners Members

Definitions:

Autologous. This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic. This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from the donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Center of Excellence for Transplants. This is any health care provider, group or association of health care providers designated by the Plan to provide services, supplies or drugs for specified transplants for covered persons.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ are not covered, except surgical implantation of FDA approved Ventricular Assist Devices (VAD) functioning as a temporary bridge to heart transplantation, or as destination therapy for member's end stage heart failure meeting the criteria specified in VAD policy.

What is covered. The plan covers eligible transplant services (as defined above) while you are a covered person. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis, and (f) heptocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support (myeloablative or non-myeloablative) associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; and (f) aplastic anemia; sickle cell anemia; non-relapsed or relapsed non-Hodgkin's lymphoma; multiple myelome; testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute leukemias for covered persons in second or subsequent remission, except for selective AML patients in first remission; (b) chemotherapy-sensitive, relapsed non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma for adolescents and young adults; (e) breast cancer stages II, III and IV; (f) neuroblastoma; (g) multiple myeloma; (h) chronic myelogenous leukemia; and (i) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas-kidney transplantation and pancreas transplant alone.
9. Small bowel transplantation.

Benefit	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. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• In an outpatient hospital or surgical facility	Annual deductible applies. $55 copay per visit	Annual deductible applies. $110 copay per visit	Annual deductible applies. $220 copay per visit	Annual deductible applies. 30% coinsurance
• In an inpatient hospital setting	Annual deductible applies. $85 copay per visit	Annual deductible applies. $180 copay per visit	Annual deductible applies. $450 copay per visit	Annual deductible applies. 25% coinsurance

Transplant services must be performed at a designated center of excellence for transplants. 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.

Benefit Features	If Services Are Autorized By Your PCC and Obtained from a Designated Transplant Center	If Services Are Not Authorized By Your PCC
V. Organ and Bone Marrow Transplant Coverage for PreferredOne Members		
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:	See Benefit Chart on page 41.	NO COVERAGE
• Allogeneic and syngeneic bone marrow for 1) Acute leukemia and chronic myelogenous leukemia, 2) Myelodysplasia, 3) Aplastic anemia, 4) Wiskott-Aldrich syndrome, 5) Cartilage-hair hypoplasia, 6) Kostmann's syndrome, 7) Infantile osteopetrosis, 8) Neuroblastoma, 9) Primary granulocyte dysfunction syndrome, 10) Thalassemia major, 11) Chronic Granulomatous disease, 12) Severe mucopolysaccharidosis, 13) Hodgkin's and non-Hodgkin's lymphoma, 14) Severe combined immunodeficiency disease 15) Mucolipidosis, 16) Myelodysplastic syndrome, 17) Sickle cell disease, 18) Multiple myeloma, 19) Ewing's sarcoma, and 20) Medulloblastoma-peripheral neuroepithelioma.	For Services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.	

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- Autologous bone marrow and autologous peripheral stem cell support for
  1) Acute lymphocytic or non-lymphocytic leukemia,
  2) Chronic myelogenous leukemia,
  3) Advanced Hodgkin's lymphoma,
  4) Advanced Non-Hodgkin's lymphoma
  5) Advanced neuroblastoma
  6) Testicular, Mediastinal, Retroperitoneal, Ovarian germ cell tumors
  7) Treatment of breast cancer,
  8) Multiple myeloma,
  9) Ewing's sarcoma, and Medulloblastoma-peripheral neuroepithelioma.
- Heart
- Heart-Lung
- Liver (cadaver and living)
- Lung (single or double)
- Pancreas transplant for
  1) a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session, or

(This column is continued on the next page.)

2) a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

- 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.

	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. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• In an outpatient hospital or surgical facility	Annual deductible applies. $55 copay per visit	Annual deductible applies. $110 copay per visit	Annual deductible applies. $220 copay per visit	Annual deductible applies. 30% coinsurance
• In an inpatient hospital setting	Annual deductible applies. $85 copay per visit	Annual deductible applies. $180 copay per visit	Annual deductible applies. $450 copay per visit	Annual deductible applies. 25% coinsurance

NOTES:

- Pre-certification is required. Transplant services must be performed at a designated transplant center. Transplant coverage includes all related post-surgical treatment and drugs. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this SB.
- Medical and hospital expenses of the donor are covered only when the recipient is a member and the transplant has been pre-certified and approved for coverage. Treatment of medical complications that may occur to the donor are not covered.
- 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.
- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for organ and bone marrow transplants listed above. See Hospital Inpatient and Physician Services.
- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the specific requirements for organ and bone marrow transplants listed above. See Hospital Inpatient and Physician Services.

EXCLUSIONS:

See Exclusions section.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
W. Maternity				
The Plan covers:				
• 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 from their Primary Care Clinic to either OB/GYN Providers associated with the PCC or to OG/GYN providers listed in the OB/GYN network (depending upon your Claims Administrator) 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.
- 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 are 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, or associated with your Primary Care Clinic.
- Please see Section IV.S, Inpatient Hospital. There will be one hospital copayment for delivery, unless the baby remains in the hospital after the mother's discharge, at which point a second copayment will be assessed.

NOT COVERED:

- Please refer to the Exclusions section.

X. Mental Illness

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 4 You Pay
If care is received:				
• In an office setting	Annual deductible applies. $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• In an outpatient hospital	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% coinsurance
• In an inpatient hospital setting	Annual deductible applies. $85 copay per admission	Annual deductible applies. $180 copay per admission	Annual deductible applies. $450 copay per admission	Annual deductible applies. 25% coinsurance
• In a licensed residential hospital setting	Annual deductible applies. $85 copay per admission	Annual deductible applies. $180 copay per admission	Annual deductible applies. $450 copay per admission	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. 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 handicapped 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.
- Requests for services involving intensive behavioral therapy programs for the treatment of autism spectrum disorders (included but not limited to ABA, IEIBT, and Lovaas) will be considered on a case by case basis.

NOT COVERED:

- Services for mental illness not listed in the most recent edition of DSM-IV
- 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

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Y. Outpatient Hospital Services				
The Plan covers: • General nursing care • Physician and other professional and medical services • Drugs administered during therapy • Radiation and chemotherapy • Kidney dialysis • 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 • Enhanced radiology services, including but not limited to CT scans, magnetic resonance imaging (MRI) and nuclear imaging. • Other diagnostic or treatment-related outpatient services • Diabetes self-management and education including medical nutrition therapy	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% coinsurance
• Scheduled surgery and all related services and supplies in an outpatient hospital or surgical facility • 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. $55 copay	Annual deductible applies. $110 copay	Annual deductible applies. $220 copay	Annual deductible applies. 30% coinsurance
• Lab and diagnostic imaging	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies. 10% coinsurance	Annual deductible applies. 30% coinsurance
• Physical, occupational and speech therapy	Annual deductible applies $17/$22 copay per visit	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• Emergency care	See Section IV.N. Emergency and Urgent Care			

NOTES:

- Refer to Sections III.A.1.f. 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.

NOT COVERED:

- Please refer to the Exclusions section.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
Z. Phenylketonuria (PKU)				
The Plan covers:				
• Special dietary treatment for phenylketonuria (PKU) when recommended by a physician	20% coinsurance, not subject to annual deductible	20% coinsurance, not subject to annual deductible	20% coinsurance, not subject to annual deductible	30% coinsurance, not subject to annual deductible

NOTE:

- 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
AA. Physician Services				
The Plan covers: • Office visits for illness or injury • Surgery or surgical services received during an office visit • Hearing aid exams, audiometric tests and audiologist evaluations which are provided by a participating Audiologist or Otolaryngologist. For Blue Cross and HealthPartners, a referral from your PCC is not necessary • Family planning services • Testing, diagnosis and treatment of infertility up to the diagnosis of infertility but not including any form of artificial insemination or assisted reproductive technologies • Allergy testing • Diabetes outpatient self-management training and education, including medical nutrition therapy	Annual deductible applies. $17/$22 copay	Annual deductible applies. $22/$27 copay	Annual deductible applies. $27/$32 copay	Annual deductible applies. $37/$42 copay
• Physician services related to a covered inpatient hospital admission • Physician services related to an emergency room visit • Physician services related to an outpatient surgery in a hospital or surgical facility • 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 sercices not included as part of preventive care and not subject to office visit or facility copayments • Physician services related to an outpatient hospital service • Enhanced radiology services, including but not limited to CT scans, magnetic resonance imaging (MRI), and nuclear imaging.	Annual deductible applies. 5% coinsurance	Annual deductible applies. 5% coinsurance	Annual deductible applies.10% coinsurance	Annual deductible applies. 25% coinsurance

NOTES:

- Female employees and/or covered female dependents may obtain direct access without a referral from their Primary Care Clinic to either OB/GYN Providers associated with the PCC or to OG/GYN providers listed in the OB/GYN network (depending upon your Claims Administrator) 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. HealthPartners members may self-refer only to specialists within the care system of their PCC.
- 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.
- 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) (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.

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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. Infertility drugs do not apply to the pharmacy out-of-pocket maximum. Drugs for the treatment of infertility are suppled, for HealthPartners members only, through Navitus Health Solutions. See Section IV.BB.

BB. Prescription Drugs and Services

Prescription drugs and services are administered by the Advantage plan's pharmacy benefit manager, Navitus Health Solutions. Members will receive a separate membership card and member handbook from Navitus.

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

Formulary Tier 1 drugs	$10 copayment for each 30-day supply
Formulary Tier 2 drugs	$16 copayment for each 30-day supply
Formulary Tier 3 drugs	$36 copayment for each 30-day supply

Certain prescription drugs may be purchased through the Navitus mail order pharmacy for two copayments for a three-month supply.

NOTES:

- A prescription is a 30-day supply from a retail pharmacy, or up to a 90-day supply from a mail service pharmacy, or a 3-cycle supply of birth control pills.
- 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 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. The formulary is available at the Navitus Web site, www.navitus.com
- Medications are covered up to a 30-day supply of medication per copayment, unless otherwise specified.
- Oral contraceptives are covered for one copayment per 3-cycle supply.
- Certain drugs require prior authorization in order for coverage to apply. These drugs are denoted with a "PA" on the formulary.
- Certain drugs have quantity limits. These drugs are denoted with a "QL" on the formulary.
- Certain over-the counter products are covered; these are listed on the formulary.
- Diabetic supplies (including test strips, lancets, and syringes) are covered with a 20% coinsurance, after annual deductible.
- Smoking cessation drugs are covered with a prescription from a physician and are listed on the formulary.
- Implantable and injectable birth control drugs and devices are covered with a 20% coinsurance.
- Certain specialty medications are required to be dispensed through Navitus SpecialtyRx. These medications are denoted with a "MSP" on the formulary.
- All other provisions in this document apply to the prescription drug benefit.
- 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 applicable copayment. When you have reached your 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.
- Dispense as written (DAW) does not override the generic requirement unless the member has appealled for and received a formulary exception.
- Navitus offers an appeal process for exceptions to the formulary. See page 51 for information on filing an appeal.

- With a written physician's prescription, the Advantage Plan will cover formulary nicotine replacement therapies.
- Tablet Splitting (RxCENTS) is a voluntary program in which, for certain Tier 1 and Tier 2 formulary drugs, a member may purchase a higher strength dosage, and split the tablets at home. Under this program, 15 tablets (half the usual quantity) are dispensed, but when split, these tablets result in a 30-day supply. Participants who use tablet splitting will pay half the normal copayment. These drugs are denoted with a "¢" on the formulary.
- Generic Waiver Program is available to encourage the use of Tier 1 Formulary medications. Under this program, the Tier 1 copayment for certain medications is waived on the initial prescription fill for up to three months if that medication has not been tried previously. These drugs are denoted with a "GW" on the formulary.
- Prescription drugs for the treatment of infertility are covered for HealthPartners members only with a 20% coinsurance. The coinsurance amount does not apply to the 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. (Claim forms are located at www.navitus.com or you may call Navitus Customer Care toll free at 866-333-2757 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. A list of participating pharmacies is available at www.navitus.com.
- Pursuant to Minn. Stat. Sec. 62Q.527, 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.

NOT COVERED:

- Drugs that the federal government has not approved for sale.
- Charges for over-the-counter drugs (except those specified on the formulary), 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.
- Drugs used for cosmetic treatments such as Retin-A, Rogaine, or their medical equivalent.
- Anorexic agents.
- 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 medially appropriate application.
- Drugs prescribed for weight loss, except those specified on the formulary.

How do I make a complaint or file an appeal?

When you have a concern about a benefit, claim or other service, please call Navitus Customer Care toll-free at 866-333-2757. Customer Care Specialists will answer your questions and resolve your concerns quickly.

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

Mail

Navitus Health Solutions

Attn: Appeals Department

P.O. Box 999

Appleton, WI 54912-0999

Fax

Navitus Health Solutions

920-831-1930

Attn: Appeals Department

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
CC. Preventive Care				
The Plan covers: • Routine physical exams • Routine gynecological exams • Routine cancer screening • Lab and diagnostic imaging • Immunizations and vaccinations; includes those needed for travel • Routine hearing exams • Prenatal and postnatal care • Routine eye exams	Nothing	Nothing	Nothing	Nothing

NOTES:

- Female employees and/or covered female dependents may obtain direct access without a referral from their Primary Care Clinic to either OB/GYN Providers associated with the PCC or to OG/GYN providers listed in the OB/GYN network (depending upon your Claims Administrator) 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.
- Benefits for routine preventive care for a child under age six (6) are listed under the Well Child Care, Section IV.II.
- 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 deductible. Should you have questions, please contact your Claims Administrator.

For PreferredOne:

- Benefits for routine physical exams are limited to one (1) per Benefit Year
- Coverage is limited to one (1) hearing exam per year.
- Coverage is limited to one (1) routine eye exam provided by a participating optometrist or ophthalmologist.

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.

DD. 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. $17/$22copay per	Annual deductible applies. $22/$27 copay per visit	Annual deductible applies. $27/$32 copay per visit	Annual deductible applies. $37/$42 copay per visit
• In an outpatient hospital or surgical facility	Annual deductible applies. $55 copay	Annual deductible applies. $110 copay	Annual deductible applies. $220 copay	Annual deductible applies. 30% coinsurance
• In an inpatient hospital setting	Annual deductible applies. $85 copay	Annual deductible applies. $180 copay	Annual deductible applies. $450 copay	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.S.
- 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
EE. Skilled Nursing Services				
The Plan covers: • Skilled Care ordered by a physician and eligible under Medicare guidelines • Semiprivate Room and board • General nursing care • Prescription Drugs and supplies used during a covered Admission, and billed through the skilled nursing facility • Physical, occupational and speech therapy	Nothing 	Nothing 	Nothing 	Nothing 

NOTE:

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

NOT COVERED:

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

Benefit Feature	
FF. 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
GG. Supplies, Durable Medical Equipment, Prosthetics and Orthotics				
Covered items include but are not limited to the following: • Durable Medical Equipment (DME), which includes: wheel chairs, hospital beds, ventilators, oxygen equipment, siderails, insulin pumps • Medical supplies, which includes: splints, nebulizers, surgical stockings, casts, medically necessary post-surgical dressings and catheter kits • Wigs coverage is limited to hair loss caused by alopecia areata - $350 maximum per Benefit Year • Covered prosthetics include: – breast prosthesis, – artificial limbs, and – artificial eyes • Initial lenses after surgery for: – cataracts, – aphakia, (Does not include progressive or no-line bifocals or anti-reflective lenses) • Initial lenses for keratoconus • 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. • Cochlear implants • Enteral feedings, when the sole source of nutrition used to treat a life-threatening condition • Medically necessary custom molded foot orthotics prescribed by a physician • 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 deductible/ HealthPartners members should use network providers	20% coinsurance not subject to annual deductible/ HealthPartners members should use network providers	20% coinsurance not subject to annual deductible/ HealthPartners members should use network providers	Annual deductible applies. 30% coinsurance

NOTES:

- Durable Medical Equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item. 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.

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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
HH. Ventilator Dependent Communication Services				
The Plan covers:				
• 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. 30% 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.

Benefit Feature	Cost Level 1 You Pay	Cost Level 2 You Pay	Cost Level 3 You Pay	Cost Level 4 You Pay
II. WELL-CHILD CARE				
The Plan covers:				
• pediatric preventive services • developmental assessments • 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.CC, 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

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 non-network 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.Y. 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 deductible level associated with your PCC.

C. BENEFIT SUBSTITUTION

Benefit substitution is a process by which the Claims Administrator's case manager works with you, your family and your health care providers to substitute one covered benefit for another covered benefit when:

1. A specific Plan benefit has been depleted; and
2. The care is medically necessary and meets the definition of skilled care; and
3. You still require the current level of care or services; and
4. Without the continued care your condition would deteriorate and/or require a higher level of care; and
5. Continuing coverage for the services would be more (or at least as) cost effective as paying for the higher level of care.

   If you use your Primary Care Clinic, or if services are authorized by your PCC, coverage is provided in an amount the Claims Administrator determines after review and prior authorization of the services. Retrospective requests for benefit substitution are not eligible. Benefit substitution is not available to allow coverage for Plan exclusions.

D. TOBACCO REDUCTION PROGRAM

BluePrint for Health tobacco reduction, a program designed to reduce tobacco use, is available to Blue Cross members. To participate, call BluePrint for Health at 800.835.0704. A tobacco cessation specialist will ask a series of questions to help get you started on the program. A unique computer program then analyzes your tobacco use behaviors and attitudes to help develop a personalized tobacco use reduction plan for you. Follow-up can be by phone or mail, whichever you prefer. You will receive materials and personalized help for up to six months. You can progress at your own pace without any pressure.

HealthPartners offers a phone-based, personalized counseling program called A Call to Change...Partners in Quitting ®. A health educator will work with you one-to-one over the phone to help you quit smoking. To register, call 952.883.7800, 800.311.1052 (outstate) or 952.883.7498 (TTY).

In addition, please refer to the Minnesota Tobacco Helpline (800.270.STOP), a smoking cessation helpline available to all Minnesotans through the Minnesota Partnership for Action Against Tobacco.

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. the portion of eligible services and supplies paid or payable under Medicare for a Medicare-enrolled member;
3. 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;
4. charges for services for or related to reconstructive surgery or cosmetic health services, except as specified in the Benefit Chart;
5. 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;
6. charges for therapeutic acupuncture except for conditions that meet medical necessity criteria as described by the medical policy on acupuncture for each Claims Administrator;
7. charges for gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling, unless medically necessary;
8. charges for marital, relationship, training services and religious counseling; charges for sex therapy in the absence of a diagnosed mental disorder;
9. 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.D. for information regarding tobacco reduction programs);
10. charges for lenses, frames, contact lenses or other fabricated optical devices, or professional services for the fitting or supply thereof, keratotomy and keratorefractive surgeries.
11. charges for services that are normally provided without charge, including services of the clergy that are normally provided without charge;
12. charges for autopsies;
13. 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);
14. charges for major organ and bone marrow transplants, including all transplant-related follow-up treatment, exams and drugs received within 365 days following transplant, except as specified in the Benefit Chart, including drug therapies;
15. 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 procedure is specifically listed as covered. Refer to Organ and Bone Marrow Transplant Coverage, Section IV.T, U, and V for specific coverage, limitations and exclusions;
16. 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;

(Continued on the next page.)

17. charges for services a Provider gives him/herself or to a close relative (such as spouse, brother, sister, parent or child);
18. 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;
19. charges for personal comfort items such as telephone, television, barber and beauty services, guest services;
20. 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;
21. 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;
22. charges for arch supports or orthopedic shoes, including biomechanical evaluation and negative foot mold impressions, except as specified in the Benefit Chart;
23. charges for or related to transportation other than local ambulance service to the nearest medical facility equipped to treat the Illness or injury, except as specified in the Benefit Chart;
24. 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.11 for information on inpatient extension of benefits);
25. charges for private-duty nursing, except ventilator dependent communication services;
26. 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.X. for further information);
27. 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;
28. 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;
29. 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;
30. 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;
31. charges for diagnostic Admission for diagnostic tests that can be performed on an outpatient basis;
32. 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;

33. charges for physical exams for purpose of obtaining employment, licensure or insurance, unless otherwise medically necessary;

34. services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits;

35. services to hold or confine a person under chemical influence when no medical services are required regardless of where the services are received;

36. 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;

37. charges for reversal of sterilization;

38. 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 intrafallopian transfer (ZIFT);

39. charges for donor ova or sperm;

40. charges for drug therapies related to infertility3;

41. charges for travel, transportation, or living expenses, whether or not recommended by a physician;

42. charges that are eligible, paid or payable 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 fair and reasonable charges;

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.

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[3] HealthPartners members may be covered for additional treatment. Please consult with your PCC regarding treatment options. Please refer to IV.AA., Physician Services, for information about coverage for the treat ment 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% (see details on Preventive Care coverage at Section IV.CC). For additional information on health and wellness resources, contact your individual health plan. Some plans offer their members resources such as classes, websites, nurse lines 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.Y) and Physician Services (Section IV.AA), as well as Miscellaneous Coverage Features (Section V.).

- Tobacco Reduction
  Quitplan® services are available to all Minnesotans at 1.888.354.7526. 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., D.)

  With a written physician's prescription, the Advantage Plan will cover formulary nicotine replacement therapies.

- Weight Management
  The Advantage Plan may cover a weight loss program if it is medically necessary, appropriate treatment and plan-approved.

- Disease Management
  The PEIP believes that good health care is important to you and your family members. Since the condition of your health impacts so many aspects of your life, a voluntary disease management program is offered to Advantage members who may qualify due to certain health/medical situations such as diabetes and asthma. This program provides you with access to 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 care goals.

  Eligible members are identified by claims data submitted to each plan's disease management program. All information is 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.

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	$50.00	$140.00	$350.00	$600.00
Family Annual Deductible	$100.00	$280.00	$700.00	$1200.00
Individual Annual Out-of-Pocket Limit for Prescription Drugs	$800.00	$800.00	$800.00	$800.00
Family Annual Out-of-Pocket Limit for Prescription Drugs	$1600.00	$1600.00	$1600.00	$1600.00
Individual Annual Out-of-Pocket Limit for all other services	$1100.00	$1100.00	$1100.00	$1100.00
Family Annual Out-of-Pocket Limit Limit for all other services	$2200.00	$2200.00	$2200.00	$2200.00
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

When you use your PCC you are also responsible for:

- Copays;
- 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 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. 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 15 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. The form will be available electronically on the Claims Administrator's secure website within 90 days of the date the Claims Administrator receives the claim and all information required to process the claims. A paper form will be mailed 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. Right of Examination

The Claims Administrator and the Plan Administrator each have the right to ask you to be examined by a Provider during the review of any claim. The Plan pays for the exam whenever the exam is requested by either the Claims Administrator or the Plan Administrator. Failure to comply with this request may result in denial of your claim.

C. 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.

D. 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]

E. Entire Contract

This Summary of Benefits and the ID cards make up the entire plan of coverage. Your employer is the plan sponsor for your coverage plan.

F. Time Limit for Misstatements

If there is any misstatement in the written application you complete, the Public Employees Insurance Program 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.

G. 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.

H. 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.

I. 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.

XI. 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. 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) PEIP Appeal Process

If a member's claim is denied initially by the Claims Administrator, the member may appeal the decision to the Public Employees Insurance Program, who will review the claim. PEIP works in concert with the Department of Health to review such appeals. Should you wish to initiate such an appeal, please call the PEIP at 651.259.3749, or write to:

Public Employees Insurance Program
Minnesota Management & Budget
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

You have the right to request an appeal by the Minnesota Department of Health or the Department of Commerce for Blue Cross members. If you wish to exercise that right, please contact the Public Employees Insurance Program at the address referenced in B(2) above. Please also refer to the Department of Health's web site at www.health.state.mn.us/divs/hpsc/mcs/options.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 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 Public Employees Insurance Program, which is charged with beginning the process of requesting the external review from the reviewer.

A $25 filing fee is required; this fee is nonrefundable if the external appeal is initiated. In cases of financial hardship, the Member can request a waiver of the fee by providing sufficient information to support the waiver request.

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 review 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.

XII. Plan Amendments

Changes to the Plan

All changes to the Plan must be approved by the Claims Administrator and the Public Employees Insurance Program 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 Public Employees Insurance Program 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 carriers or Providers; to remove a Claims Administrator from the Public Employees Insurance Program; and to limit the geographic area serviced by the Claims Administrator covering employees under the Public Employees Insurance Program.

XIII. 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 XIII.

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.

XIV. 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.

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, and other methods, the Claims Administrator may subsequently adjust the amount due to a participating Provider. These subsequent adjustments will not impact or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Claims Administrator or the Plan 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. For HealthPartners, the Allowed Amount for Nonparticipating Providers is the billed charge.

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 semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

Benefit Chart The charts in Sections IV and VI 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 the Employer.

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 Navitus Health Solutions.

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. When your coinsurance is calculated on the billed charge rather than the allowed amount for Participating Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage.

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

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

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.

Mail Order Pharmacy An authorized pharmacy that dispenses prescription drugs through the U.S. Mail.

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

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

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% 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 copays and/or prescription drug deductibles do not apply to the 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 Administrator The Minnesota Public Employees Insurance Program (PEIP).

Plan Sponsor Your employer.

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% 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 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.

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 Pharmacy Navitus Health Solutions has contracted with 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

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

Third Party Administrator (TPA) A company under contract to the Minnesota PEIP to provide certain administrative services. The organization is Innovo Benefits, 8220 Commonwealth Drive, #150, Eden Prairie, MN 55344.

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.

XV. 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.

XVI. Medical Data Privacy

Introduction

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). While the PEIP Advantage Health Plan ("the Plan") has always taken care to protect the privacy of your health information, the new regulations require the Plan to adopt more formal procedures and to tell you about these procedures in this document. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

A. The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information ("PHI") to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to Health Care Treatment, Payment, and Health Care Operations.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;
2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
3. Subrogation;
4. Coordination of Benefits;
5. Establishing self-payments by persons covered under the Plan;
6. Billing and collection activities;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;
8. Obtaining payment under stop-loss or similar reinsurance;
9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;
12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;
3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:
   A. Managing activities related to implementing and complying with the Privacy Regulations;
   B. Resolving claim appeals and other internal grievances;
   C. Merging or consolidating the Plan with another Plan, including related due diligence; and
   D. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

C. Release of PHI to the Plan Administrator

The Plan will disclose PHI to the Plan Administrator. The Plan has received a certificate from the Plan Sponsor that the plan documents, including this Summary of Benefits, have been amended to incorporate the following provisions.

The Plan Administrator will receive and use PHI only for the Plan administration functions that the Plan Administrator performs for the Plan. In addition, the Plan Administrator will:

1. Not use or further disclose PHI other than as permitted or required by the Summary of Benefits or as required by law.
2. Ensure that any agents to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;
6. Make PHI available to any person who is the subject of the information according to the Privacy Regulations' requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;
8. Make available the PHI required to provide an accounting of disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator maintains in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Plan Administrator Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Plan Administrator.

   The Plan will release PHI to the Plan Administrator, and the Plan Administrator will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

2. The Plan Administrator's agents, only to the extent reasonable to assist the Plan Administrator in fulfilling their duties consistent with the above uses and disclosures of PHI.

3. The Plan Administrator's employees, only to the extent reasonable to assist the Plan Administrator in fulfilling its duties consistent with the above uses and disclosures of PHI.

E. Noncompliance Issues

If the persons described above do not comply with this Summary of Benefits, the Plan Administrator will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

F. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person.