For employees of:

Knife River Corporation

HSA 1 W/ RX

PLEASE READ YOUR BENEFIT BOOKLET CAREFULLY

Language Access Services

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

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

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကိုဉ်ဒီး, တ်ကဟ့ဉ်နၤကျိုတ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီ, ကိး 711 တက့ာ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ຂ່າວັບ. TTY, ໃຫ້ໂທຫາ 711.

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

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

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

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Koji éí béésh bee hodíílnih áǫięęǫíǫáǫąęią. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Knife River Corporation
About Your Prescription Drug Coverage and Medicare
Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with Knife River Corporation and about your options under Medicare's prescription drug coverage. This information can help decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you enroll in a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Knife River Corporation has determined that the prescription drug coverage offered by the Knife River Corporation health care plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are considered Creditable Coverage.**

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

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. This may mean that you may have to wait to enroll in a Medicare prescription drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Medicare prescription drug plan at that time using an Employer Group Special Enrollment Period.

If you do decide to enroll in a Medicare prescription drug plan and drop your Knife River Corporation medical plan with prescription drug coverage, be aware that you and your dependents may not be able to get your Knife River Corporation coverage back. Knife River Corporation will offer prescription drug coverage benefits to you in 2024. If you enroll in Medicare Part D, you become ineligible for coverage under the Knife River Corporation health care plans. If you drop your coverage with Knife River Corporation and enroll in a Medicare prescription drug plan, you may be paying an additional premium for coverage that you already have. You should compare your current coverage, including which drugs are covered, with the coverage and cost of plans offering Medicare prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with Knife River Corporation and do not enroll in Medicare prescription drug coverage within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug

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

For more information about this notice or your current prescription drug coverage contact our office by calling 701-530-1416. Note: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Knife River Corporation changes. You also may request a copy of this notice at any time. More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	January 1, 2024
Name of Entity/Sender:	Knife River Corporation
Contact:	Retiree Benefits Department
Phone:	(701) 530-1416
Address:	1150 West Century Ave, Bismarck, ND 58503

Notice of Nondiscrimination Practices

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with the claims administrator.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact the claims administrator at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting the claims administrator at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting the claims administrator at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Questions?

Whether it is for help with a claim or a question about your benefits, you can call your customer service telephone number or log onto the claims administrator's member website both located on the back of your ID card.

A customer service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

The customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.

Identification (ID) Card

If your card is lost or stolen, or contains inaccurate information, please contact customer service immediately at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at bluecrossmn.com.

Table of Contents

Welcome

This benefit booklet provides you with the information you need to understand your health plan. You are encouraged to take the time to review this information so you understand how your health plan works.

This benefit booklet replaces all other certificates/benefit booklets you have received from the plan administrator before the effective date. For purposes of this benefit booklet, "you" or "your" refers to the employee named on the identification (ID) card and other covered dependents. Employee is the person for whom the employer has provided coverage. Dependent is a covered dependent of the employee.

The plan administrator has contracted with the claims administrator to provide coverage for its employees and their dependents. Terms are defined in "Terms You Should Know."

This benefit booklet explains the health plan, eligibility, notification procedures, covered services, and expenses that are not covered. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, please contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at bluecrossmn.com.

This plan, financed and administered by Knife River Corporation, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the claims administrator and provides administrative services only. The claims administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have any questions on your health plan, please contact customer service at the telephone number listed on the back of your member ID card.

Services Rendered in Alaska:

Certain In-Network specialists are not available in your area. These specialists include orthopedic surgeons (Anchorage only), otolaryngologists (ENT), gastroenterologists, and in certain cases, may include other specialty providers. If you are unable to locate an In-Network Provider in your area, you can access either an In-Network or Out-of-Network Provider for these specialties. Regardless of whether you utilize an In-Network or Out-of-Network Provider for these services, the claims will be paid at the In-Network level using allowed amounts. These expenses will apply toward In-Network deductibles and In-Network out-of-pocket maximums, when applicable.
If you have any questions on your health care Plan, please call Member Service at the telephone number listed on the back of your member ID card.

Member Rights and Responsibilities

You have the right as a health plan member to:

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

You have the responsibility as a health plan member to:

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

Benefit Overview

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

Benefit Period

Your health plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31.

During this time, charges for covered services must be incurred in order to be eligible for payment by Blue Cross. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Networks	
Your online provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan. To find an in-network provider, visit bluecrossmn.com ("Member Log in" then "Find a Doctor") or contact customer service at the telephone number listed on the back of your member ID card.	
• In-network Providers ▪ In Minnesota ▪ Outside Minnesota	 Aware network providers BlueCard PPO network providers
• In-network Participating Pharmacy Providers	Select pharmacy network

General Provisions		
Benefits	**In-network Providers**	**Out-of-network Providers**
Deductible including pharmacy • Individual • Family	 You pay $2,000 You pay $4,000	 You pay $4,000 You pay $8,000
Deductible - Non-embedded If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The individual deductible applies to individual coverage only.		
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 40% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year

General Provisions		
Benefits	**In-network Providers**	**Out-of-network Providers**
Out-of-pocket Limits - eligible medical services including pharmacy		
• Individual	You pay $4,000	You pay $5,000
• Family	You pay $8,000	You pay $10,000
Out-of-pocket Limit - Non-embedded If you have other family members on the plan, the overall family out-of-pocket limit must be met. The individual out-of-pocket limit applies to individual coverage only.		
Lifetime Maximum (per person)		
• Assisted reproductive technology		
▪ medical services	$10,000	
▪ prescription drugs	$10,000	
• Travel expenses for transplants to a Blue Distinction Center only	$5,000	
• Total benefits paid to all other providers combined	Not applicable	

Prescription Drug Benefits	In-network Provider	Out-of-network Provider
Prescription Drugs: • **Affordable Care Act (ACA) preventive covered prescription drugs**	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	NO COVERAGE
• **Designated preventive prescription drugs other than Affordable Care Act (ACA) preventive prescription drugs**	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	NO COVERAGE

Prescription Drug Benefits	In-network Provider	Out-of-network Provider
• **Value Based Benefit Design (VBBD) Drugs (other than Affordable Care Act (ACA) preventive prescription drugs)** ▪ Tier 1 VBBD drugs	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	NO COVERAGE
▪ Tier 2 VBBD drugs	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	NO COVERAGE
▪ Tier 3 VBBD drugs	**Retail Pharmacy:** You pay nothing **90dayRx Participating Retail Pharmacy:** You pay nothing **Mail Service Pharmacy:** You pay nothing	NO COVERAGE
• **FlexRx Preferred generic prescription drugs**	**Retail Pharmacy:** You pay 20% coinsurance after deductible **90dayRx Participating Retail Pharmacy:** You pay 20% coinsurance after deductible **Mail Service Pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE
• **FlexRx Preferred brand prescription drugs**	**Retail Pharmacy:** You pay 20% coinsurance after deductible **90dayRx Participating Retail Pharmacy:** You pay 20% coinsurance after deductible **Mail Service Pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE
• **Non-preferred generic prescription drugs**	**Retail Pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE

Prescription Drug Benefits	In-network Provider	Out-of-network Provider
	90dayRx Participating Retail Pharmacy: You pay 20% coinsurance after deductible **Mail Service Pharmacy:** You pay 20% coinsurance after deductible	
• **Non-preferred brand prescription drugs**	**Retail Pharmacy:** You pay 20% coinsurance after deductible **90dayRx Participating Retail Pharmacy:** You pay 20% coinsurance after deductible **Mail Service Pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE
• **Retail Pharmacy Vaccine program** ▪ certain eligible vaccines administered at a participating retail pharmacy	You pay nothing	NO COVERAGE

Benefit Chart

The health plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate and be in accordance with any treatment plan prescribed by your treating health care provider. All benefit limits, deductibles and copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Except as specifically provided in the health plan or as mandated or required to be provided based on state or federal law, no benefits will be provided for services, supplies, prescription drugs, or charges that are noted under “Not Covered” in the benefit charts or in the “General Exclusions.”

Prior authorization, admission notification, emergency admission notification, and continued stay approvals are required for specific services. Please refer to "Health Care Management." You are required to obtain prior authorization and continued stay approvals for specific services when you use nonparticipating providers in Minnesota and any provider outside of Minnesota. For more information, please call customer service at the telephone number listed on the back of your member ID card.

Benefit Descriptions

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

Ambulance

The Plan Covers:	In-network Providers	Out-of-network Providers
• Emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services
• Non-emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services

Ambulance – Notes

1. Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
   a. from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
   b. between hospitals; or
   c. between a hospital and a skilled nursing facility provider;

   when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
2. Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
3. Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.
4. Eligible services you receive from out-of-network providers apply to the in-network deductible.
5. Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

Ambulance – Not Covered

1. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility capable of treating your condition (example: facility A is the closest medical facility capable of treating your condition but you are transported to facility B. The plan will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you are transported by ambulance to facility B, the cost of transportation service in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs).
2. Travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein.
3. Ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support.
4. Transportation services, including ambulance services that are mainly for your convenience.

Ambulance – Not Covered
5. Transportation to a residence. 6. Conventional air services, such as commercial airlines.

Behavioral Health Mental Health Care

Your mental health is just as important as your physical health. That is why your health plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telehealth services ▪ individual/group/family therapy (office/in-home mental health services)	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ assessment and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Professional health care services including: ▪ clinic-based partial programs ▪ clinic-based day treatment ▪ clinic-based Intensive Outpatient Programs (IOP)	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Facility health services including: ▪ hospital-based partial programs ▪ hospital-based day treatment ▪ hospital-based Intensive Outpatient Programs (IOP)	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

The Plan Covers:	In-network Providers	Out-of-network Providers
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Behavioral Health Mental Health Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. For home health related services, please refer to "Home Health Care."
3. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
4. Coverage is provided for crisis evaluations delivered by mobile crisis units.
5. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a licensed psychiatrist or a doctoral level licensed psychologist, is deemed medically necessary and appropriate.
6. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this health plan.
7. Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
8. Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
9. Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
10. Coverage is provided for inpatient care and outpatient care for the treatment of mental illness. A mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts.
11. Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient.
12. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
    a. mental health and substance use disorder services are to be covered on the same basis as similar medical services;
    b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
    c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
13. Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
14. Benefits are provided for intensive behavioral therapy programs including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Applied Behavioral Analysis (ABA), Intensive Behavioral Intervention (IBI), and Lovaas Therapy for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

Behavioral Health Mental Health Care – Notes
15. The plan covers telehealth services.

Behavioral Health Mental Health Care – Not Covered
1. Services related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM).* 2. Custodial care. 3. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) offences; competency evaluations; adoption home status; parental competency; and domestic violence programs. 4. Services or room and board for foster care, group homes, shelter care and lodging programs, and halfway house services. 5. Services for skills training. 6. Services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as provided herein. 7. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning). 8. Educational services for the treatment of learning disabilities. 9. Services for therapeutic day care and therapeutic camp services. 10. Services for or related to marriage/couples counseling.

Behavioral Health Substance Use Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services including: ▪ office visit ▪ telehealth services ▪ individual/group/family therapy	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services ▪ opioid treatment, including Medication Assisted Treatment (MAT)	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment, including Medication Assisted Treatment (MAT)	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ Intensive Outpatient Programs (IOP) and related aftercare services ▪ partial hospitalization	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Inpatient health care professional services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Inpatient hospital/facility services • Residential behavioral health treatment facility services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Behavioral Health Substance Use Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
3. Benefits provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
   a. inpatient hospital or substance use disorder treatment facility provider services for detoxification;
   b. substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services;
   c. outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy;
   d. court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections;
   e. admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold; and
   f. coverage includes Medication Assisted Treatment (MAT) for opioid use disorder.
4. For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Behavioral Health Substance Use Care – Notes

5. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
6. For home health related services, please refer to "Home Health Care."
7. For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
8. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
   a. mental health and substance use disorder services are to be covered on the same basis as similar medical services;
   b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
   c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
9. The plan covers telehealth services.

Behavioral Health Substance Use Care – Not Covered

1. Services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
2. Custodial care.
3. Services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate.
4. Evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs.
5. Services or room and board for foster care, group homes, shelter care, and lodging programs, and halfway house services.
6. Services for skills training.
7. Substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition.
8. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
9. Services for therapeutic day care and therapeutic camp services.
10. Services for hippotherapy (equine movement therapy).

Chiropractic Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Spinal manipulations - includes office visit	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Other chiropractic services including therapies	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Acupuncture services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Chiropractic Care – Notes

1. Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
2. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
3. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.
4. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.

Chiropractic Care – Not Covered

1. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider.
2. Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
3. Services for or related to therapeutic massage.
4. Maintenance services.
5. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition.
6. Custodial care.

Dental Care

The Plan Covers:	In-network Providers	Out-of-network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Diagnostic evaluation, surgical and nonsurgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD) including: ▪ orthognathic surgery ▪ related orthodontia	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Dental Care – Notes
1. For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. 2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care." 3. Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures. 4. Bone grafts (the building up of bone in the upper or lower jaw) for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis. 5. Sound natural teeth means teeth and tissue that are viable, functional and free of disease. A sound natural tooth: a. has no decay, b. has no filling on more than two (2) surfaces, c. does not have bone loss of more than 50%, d. has not had a root canal procedure (removing the tissue inside the tooth root), and e. has not been replaced by any artificial means (for example, implants, fixed or removable bridges, dentures, dental appliance, or crowns). 6. Accident-related dental services, treatment and/or restoration of a sound natural tooth must begin within 12 months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound natural teeth, crowns, fillings and bridges. 7. The health plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted. 8. Services for diagnostic evaluation, surgical, and nonsurgical treatment of temporomandibular disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

Dental Care – Not Covered
1. Services for or related to orthodontia, except as provided herein. 2. Oral surgery procedures, except as provided herein. 3. Services for or related to treatment of cracked or broken teeth due to biting or chewing. 4. Dentures, regardless of the cause or the condition, and any associated services including bone grafts. 5. Dental implants and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19. 6. Removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein. 7. Services for or related to replacement of a damaged dental bridge from an accident-related injury. 8. Osteotomies (cutting of the bone), osteoplasty (building up the bone), and other procedures associated with the fitting of dentures or dental implants, except as provided herein. 9. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein. 10. Services to treat bruxism (excessive grinding of teeth or clenching of the jaw), including dental splints. 11. Charges for routine dental care, except as provided herein. 12. Services for or related to gingival and periodontal (the gums and bone that surround and support the teeth) procedures.

Emergency Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services
• Outpatient hospital/facility services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after deductible	Same as in-network services

Emergency Care – Notes
1. In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a medical emergency the claims administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
2. For follow up care, please refer to "Hospital Outpatient Care," "Hospital Inpatient Care" and "Office Visit and Professional Services."
3. In some circumstances where you were not able to choose the provider who rendered care, you are not responsible for any amounts above what you would have been required to pay (such as deductibles) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. Please refer to "Special Circumstances."
4. If the care you receive is due to a medical emergency, prior authorization is not required.
5. Please refer to "Terms You Should Know" for a definition of medical emergency.
6. For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
7. For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
8. Eligible services you receive from out-of-network providers apply to the in-network deductible.
9. Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

Home Health Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care and other home care services ordered by a physician and provided by employees of an approved home health agency including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietitian ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with covered services ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Home Health Care – Notes
1. Intermittent skilled nursing care consists of up to two (2) consecutive hours of care per date of service in the member’s home. 2. Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services. 3. Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy." 4. For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies." 5. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 6. Home health care limit: 120 visits per person per calendar year. The one (1) home health care visit following early maternity discharge does not apply to the 120 visit limit. 7. Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child.

Home Health Care – Not Covered
1. Homemaker services. 2. Maintenance services. 3. Services for dialysis treatment you receive from a home health agency. 4. Custodial care. 5. Services for food or home-delivered meals you receive from a home health agency. 6. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospice Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Hospice care for terminal condition	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Hospice Care – Notes
1. Benefits are limited to members with a terminal condition, which requires the member's primary physician to certify, in writing, a life expectancy for the member of six (6) months or fewer. Hospice benefits begin on the date of admission to a hospice program. 2. Hospice program inpatient respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days at a time. 3. Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program. 4. Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting. 5. Benefits include family counseling related to the member's terminal condition. 6. Medical care services unrelated to the terminal condition under the hospice program are covered but are separate from the hospice benefit.

Hospice Care – Not Covered
1. Services for respite care, except as provided herein. 2. Room and board expenses in a residential hospice facility. 3. Services for dialysis treatment you receive from hospice or a hospital program for hospice care. 4. Custodial care. 5. Services for food or home-delivered meals you receive from hospice or a hospital program for hospice care.

Hospital Inpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Hospital room and board, and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Hospital Inpatient Care – Notes
1. The health plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition. 2. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: a. potential donor testing; b. donor evaluation and work-up; and c. hospital and professional services related to organ procurement. 3. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine; b. diagnostic pathology consisting of laboratory and pathology tests; c. diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Hospital Inpatient Care – Notes
4. The health plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. 5. The plan covers telehealth services.

Hospital Inpatient Care – Not Covered
1. Charges for inpatient admissions which are primarily for diagnostic studies. 2. Personal comfort items such as telephone, television. 3. Communication services provided on an outpatient basis or in the home. 4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospital Outpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient hospital/facility services • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Laboratory services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Facility billed freestanding ambulatory surgical center services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Urgent care center visits including: ▪ facility billed services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ facility laboratory services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ facility diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Hospital Outpatient Care – Notes
1. Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient. 2. Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery. 3. Coverage is provided for anesthesia, anesthesia supplies and devices rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.

Hospital Outpatient Care – Notes
4. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 5. The health plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. 6. Assisted reproductive technology services are subject to a lifetime maximum limit of $10,000 per person for medical services only. 7. The plan covers telehealth services.

Infusion Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
• Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Infusion Therapy – Notes
1. Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting. 2. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

Infusion Therapy – Not Covered
1. Home/suite infusion services or supplies not specifically listed as covered services. 2. Nursing services to administer home/suite infusion therapy when the patient or caregiver can be successfully trained to administer therapy.

Maternity Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Prenatal hospital/facility provider services	You pay nothing	NO COVERAGE
• Prenatal professional services	You pay nothing	NO COVERAGE
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ postpartum care • office visit	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• all other eligible services - office/clinic	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• all other eligible services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Inpatient hospital/facility services for: ▪ delivery in a hospital/facility ▪ postpartum care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Acupuncture services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Maternity Care – Notes

1. Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child.
2. If you think you are pregnant, you may contact your physician or go to an in-network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.
3. Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
4. Hospital, medical and surgical services rendered by a facility provider or professional provider for:
   a. Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy. Services related to miscarriage, ectopic pregnancy or those that require cesarean section are covered as delivery.
   b. Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, gestational diabetes screening, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.
5. Under federal law, group health plans such as this plan are required to provide benefits for any hospital length of stay in connection with childbirth as follows:
   a. inpatient hospital coverage for the mother (to the extent the mother is covered under this health plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health plan. Please refer to "Home Health Care."

Maternity Care – Notes
b. inpatient hospital coverage for the newborn (to the extent the newborn is covered under this health plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this plan. Please refer to "Home Health Care." 6. Under federal law, the health plan may require that a provider obtain authorization from the health plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above. 7. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." 8. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.

Maternity Care – Not Covered
1. Health care professional services for childbirth deliveries in the home. 2. Services for or related adoption fees. 3. Services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted reproductive technology, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan. 4. Services for childbirth classes. 5. Services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue. 6. Services for donor ova or sperm. 7. Services for or related to an elective cesarean (C)-section for the purpose of convenience. 8. Services and prescription drugs for or related to the selection of gender in embryos. 9. Services for or related to elective termination of a normal pregnancy are not covered unless it is determined by the attending physician to be medically necessary and appropriate.

Medical Equipment and Supplies

The Plan Covers:	In-network Providers	Out-of-network Providers
• Durable medical equipment (DME) • Amino acid-based elemental formula • Continuous Glucose Monitors (CGMs) • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Insulin infusion devices	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Blood Glucose Meters (BGMs)	You pay nothing	You pay 40% coinsurance after deductible
• Orthotics	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Prosthetics, such as breast prostheses, artificial limbs, and artificial eyes	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Cochlear implants	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Non-investigative bone conductive hearing devices	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Medical Equipment and Supplies – Notes

1. The health plan covers the approved rental, purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.
2. Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
   a. equipment and supplies: all physician prescribed medically necessary and appropriate equipment and supplies, including but not limited to, blood glucose monitors, monitor supplies, and insulin infusion devices.
3. The health plan covers the approved rental, purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use including supplies and accessories necessary for the effective functioning of covered durable medical equipment.
4. Rental costs cannot exceed the total cost of purchase.

Medical Equipment and Supplies – Notes
5. Amino acid-based elemental formula, a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. An infant or child may be placed on an amino acid-based formula when unable to digest or tolerate whole proteins found in other formulas due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino, and E028 Neocate Splash.
6. The health plan covers the approved rental, purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part.
7. Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
8. Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.

Medical Equipment and Supplies – Not Covered
1. Services for or related to hearing aids or devices, except as provided herein.
2. Durable medical equipment, supplies, and prosthetics for convenience, personal, or recreational use.
3. Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants.
4. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.
5. Blood pressure monitoring devices.
6. Replacement of properly functioning durable medical equipment.
7. Repair, maintenance or replacement of rental equipment (this is included in the price of the rental equipment).
8. Duplicate equipment, prosthetics, or supplies.
9. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
10. Devices for maintenance services.
11. Biofeedback devices in the home.
12. Wigs (scalp hair prostheses) for any diagnosis.
13. Charges for breast pumps, except as provided herein.
14. Services for eyeglasses or contact lenses, or prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

Office Visit and Professional Services

The Plan Covers:	In-network Providers	Out-of-network Providers
• General physician office visits	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Specialist physician office visits	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• E-visits • Telephone consultations	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Urgent care center visits including: ▪ office visit for urgent care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ professional laboratory services for urgent care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ professional diagnostic imaging services for urgent care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services for urgent care	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Retail health clinic ▪ retail health clinic office visit	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ laboratory services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
▪ all other professional services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Professional billed services received at a freestanding ambulatory surgical center	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Omada program for members age 18 or older for: ▪ pre-diabetes/pre-cardiac ▪ diabetes management	You pay nothing	NO COVERAGE
• Hinge Health musculoskeletal (MSK) condition management program	You pay nothing	NO COVERAGE
• Acupuncture services	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Assisted reproductive technology	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

The Plan Covers:	In-network Providers	Out-of-network Providers
• All other professional services – office/clinic	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• All other professional services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Office Visit and Professional Services – Notes

1. Diabetes Self-Management Education and Support (DSMES) Services: When your health care provider certifies that you require diabetes education and support, coverage is provided for the following situations when rendered through DSMES services:
   a. when diabetes is diagnosed;
   b. when a new medication is prescribed;
   c. when diagnosed with diabetes and you are at risk for complications including, but not limited to, having problems controlling your blood sugar, been treated in the emergency room or experienced a hospital stay, diagnosed with eye disease related to diabetes, experiencing a lack of feeling in your feet or other foot problems, or been diagnosed with kidney disease related to diabetes.

   DSMES may be provided individually or in a group setting.
2. If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
3. Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
4. The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
5. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy.
6. A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
7. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan:
   a. potential donor testing;
   b. donor evaluation and workup; and
   c. hospital and professional services related to organ procurement.
8. The plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
9. Diagnostic services include the following when ordered by a health care provider:
   a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
   b. diagnostic pathology consisting of laboratory and pathology tests
   c. diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
   d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Office Visit and Professional Services – Notes

10. Eligible therapeutic drugs, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider and eligible under the "Office Visit and Professional Services" benefit. For injectable medications billed by a pharmacy or specialty drugs billed by the participating specialty pharmacy network provider, please refer to "Prescription Drugs." For specialty drugs that are administered in a clinic or an outpatient hospital, your health care provider may be required to obtain the specialty drugs from a designated vendor.
11. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
12. The plan covers services for or related to growth hormone replacement therapy if it is determined to be medically necessary and appropriate and otherwise covered under this health plan.
13. Please refer to “Preventive Care” for female sterilization.
14. Omada delivers the largest CDC recognized prevention program for high-risk (pre-diabetes/pre-cardiac) conditions. Eligible members age 18 and older may participate in the digital care program, personalized to meet each eligible participant’s unique needs, as they evolve. The Omada for prevention program helps participants lose weight (and keep it off), build strategies for healthy eating, activity, sleep, and stress management, and reduce the risk of developing diabetes and cardiovascular disease – one (1) step at a time. Each participant is given a professional health coach, connected devices, including a digital scale, online peer community, weekly interactive lessons and insight driven health goals.
15. Omada provides eligible members age 18 and older with a personalized digital care program for those with diabetes. They combine our deep expertise in behavior change with features designed to help participants achieve target blood glucose levels, minimize episodes of very high and very low blood glucose, address common questions about diabetes or cholesterol medications, get the most out of primary care provider visits, and make achievable lifestyle changes to lose weight if needed (and keep it off). In addition to support for diet, activity, stress, sleep, and weight monitoring, Omada for Diabetes Management provides:
    a. coaching from a Certified Diabetes Care and Education Specialist (CDCES);
    b. diabetes curriculum based on DSMES (Diabetes Self-Management Education and Support);
    c. remote blood glucose monitoring;
    d. diabetes peer group support; and
    e. medication self-management.
16. E-visit is a patient-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient. For more information about virtual care options, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.
17. The plan covers telehealth services.
18. The plan covers at-home exercise therapy for members experiencing musculoskeletal (MSK) related joint, bone or muscle pain. This MSK Condition Management Program provides a holistic approach from prevention, to acute, to chronic, to pre- and post-surgical care. The MSK Condition Management Program utilizes a unique, non-invasive pain management device as well as sensor and computer-vision based technology to partner a member with a Hinge Health physical therapist and health coach to provide up to 365 days of therapy and education. To register, please visit the member website at bluecrossmn.com.
19. Therapeutic injections include coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one (1) that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one (1) of the standard compendia or in one (1) article in the medical literature as specified by law.
20. For self-administered prescription drugs, please refer to “Prescription Drugs.”

Office Visit and Professional Services – Notes
21. If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the medical benefit. Medical and behavioral health policy guidelines are available on our website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believe that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one (1) of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the drug if it is a covered prescription drug under your plan.
22. Assisted reproductive technology services are subject to a lifetime maximum limit of $10,000 per person for medical services only.
23. The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.
24. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.

Office Visit and Professional Services – Not Covered
1. Out-of-network provider-initiated communications.
2. Services for autopsies.
3. Separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider.
4. Services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein.
5. Services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
6. Services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider.
7. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
8. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
9. Services for or related to reversal of sterilization.

Physical, Occupational, and Speech Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
• Habilitative and rehabilitative office visits from a physical therapist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative therapies from a physical therapist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative office visits from an occupational therapist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative therapies from an occupational therapist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative office visits from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible
• Habilitative and rehabilitative therapies from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Physical, Occupational, and Speech Therapy – Notes

1. Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
2. For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
3. Office visits may include an evaluation or re-evaluation of the following therapies:
   a. physical;
   b. occupational;
   c. speech; or
   d. swallowing.
4. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

Physical, Occupational, and Speech Therapy – Not Covered

1. Services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider.
2. Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

Prescription Drugs

The Plan Covers:	In-network Providers	Out-of-network Providers
• Prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets • Prescription drugs that are self-administered and do not require the services of a health care professional, except for designated specialty drugs (see Notes below) • Insulin • Affordable Care Act (ACA) preventive covered prescription drugs • Value based benefit design (VBBD) drugs other than Affordable Care Act (ACA) Preventive Prescription Drugs • FDA-approved tobacco cessation drugs and products, subject to limitations below • Retail pharmacy vaccine program ▪ certain eligible vaccines administered at a participating retail pharmacy (see Notes below)	Please refer to "Prescription Drug Benefits" in "Benefit Overview."	Please refer to "Prescription Drug Benefits" in "Benefit Overview."

Prescription Drugs – Notes
1. Covered prescription drugs include drugs listed in your health plan's covered drug list; including compounded medications, consisting of the mixture of at least two (2) or more FDA-approved prescription drugs/medications. (Please refer to “Terms You Should Know.”) 2. The claims administrator’s covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Cross Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year. 3. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day. 4. The claims administrator chooses which drugs are on its drug lists, or excluded from its drug lists, based on numerous factors including their quality, safety and effectiveness, and overall cost. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a drug list while the generic of the same drug is excluded from a drug list. 5. To receive a copy of your covered drug list visit bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. 6. The drug list is subject to periodic review and modification by the claims administrator or a designated committee of physicians and pharmacists. 7. A retail pharmacy is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible prescription drugs and diabetic supplies are generally covered up to a 31-day supply. 8. 90dayRx includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy. Eligible prescription drugs are dispensed up to a 90-day authorized supply of ongoing, long-term prescription drugs.

Prescription Drugs – Notes

9. The health plan will cover off-label prescription drugs used for cancer treatment as specified by law. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one (1) of the standard compendia or in one (1) article in the medical literature as specified by law.
10. Amino acid-based elemental formula is considered a supply item. Please refer to “Medical Equipment and Supplies.”
11. Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
12. There may be circumstances where early or extended prescription drug refills are available. Please contact customer service at the telephone number listed on the back of your member ID card for further information. Restrictions apply.
13. The claims administrator may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain prescription drugs covered under the health plan. Such discounts are the sole property of the claims administrator and/or the health plan and will not be considered in calculating any coinsurance, copay, deductible, or benefit maximums, except as required by law.
14. Digital therapeutics (the use of personal health devices and sensors, either alone or on combination with conventional drug therapies, for disease prevention and management) when dispensed through a pharmacy and deemed eligible for coverage.
15. The plan covers a range of FDA-approved preventive contraceptive methods for women with reproductive capacity. Medical management may apply. Please also refer to “Preventive Care.”
16. Benefits are provided for designated ACA preventive drugs with a prescription which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
17. For more information regarding contraceptive or ACA preventive prescription drug coverage, please visit bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card.
18. The claims administrator applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications where a $0 member cost-sharing applies. If your prescribing health care professional determines that none of the $0 member cost-sharing options available under your plan are clinically appropriate for you, they may request an exception. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card.
19. Covered prescription drugs also include selected specialty prescription drugs within, but not limited to, the following prescription drugs classifications only when such prescription drugs are covered medications and are dispensed through exclusive specialty pharmacy network supplier. Specialty prescription drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty prescription drugs are prescription drugs including, but not limited to prescription drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated specialty prescription drugs and suppliers is available at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. Specialty prescription drugs are not available through 90dayRx.
20. Specialty prescription drugs may be ordered by a health care provider on your behalf or you may submit the prescription order directly to the specialty pharmacy network supplier. In either situation, the specialty pharmacy network supplier will deliver the prescription to you.
21. The retail pharmacy vaccine program allows you the opportunity to receive certain otherwise eligible vaccines at designated participating retail pharmacies subject to your prescription drug cost-sharing. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated participating pharmacies is available on our website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card.

Prescription Drugs – Notes

22. If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the prescription drug benefit. Step therapy prescription drug categories are available on our website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medically necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one (1) of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the prescription drug if it is a covered prescription drug under your plan.
23. If you are prescribed a brand drug or biosimilar when there is an equivalent generic drug or biosimilar, you will also pay the difference in cost between the brand drug or biosimilar and the generic drug or biosimilar, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket limit, you still pay the difference in cost between the brand drug or biosimilar and the generic drug or biosimilar, even though you are no longer responsible for the applicable prescription drug member cost-sharing. You are also responsible for the payment differential when a generic drug or biosimilar is authorized by the physician and you purchase a brand drug or biosimilar. Your payment is the price difference between the brand drug or biosimilar and generic drug or biosimilar in addition to the brand drug cost-sharing amounts that apply.
24. Self-administered injectable and oral prescription drugs for assisted reproductive technology must be obtained through a specialty pharmacy network supplier and are subject to the lifetime maximum limit of $10,000 per person.

Prescription Drugs – Not Covered

1. Services you receive from an out-of-network provider.
2. Any charges by any pharmacy provider or pharmacist, except as provided herein.
3. Any prescription for more than the days supply or 90dayRx days supply as outlined in the “Benefit Overview,” except as provided herein.
4. Charges for any drug purchased through mail service but not dispensed by a designated mail service pharmacy provider.
5. Services for or related to tobacco cessation drugs and program fees and/or supplies, except as provided herein.
6. Medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. Covered medical devices are generally submitted and reimbursed under your medical benefits, please refer to “Medical Equipment and Supplies.”
7. Specialty drugs not purchased through a specialty pharmacy network supplier.
8. Drugs removed from the covered drug list due to safety reasons may not be covered.
9. Over-the-counter drugs, except as provided herein.
10. Tobacco cessation drugs and products without a prescription.

Preventive Care

The Plan Covers:	In-network Providers	Out-of-network Providers
Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), and the Internal Revenue Service (IRS). For more information regarding preventive care services, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.		
• Adults and children age six (6) and older ▪ preventive physical examinations	You pay nothing	NO COVERAGE
▪ hearing screening	You pay nothing	NO COVERAGE
▪ adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease	You pay nothing	NO COVERAGE
▪ diagnostic services and procedures ▪ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	NO COVERAGE
▪ routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	NO COVERAGE
▪ mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	NO COVERAGE
▪ colorectal cancer screening ▪ prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	NO COVERAGE
• Infants and children ▪ preventive physical examinations from birth to age six (6) ▪ developmental assessments from birth to age six (6)	You pay nothing	NO COVERAGE
▪ pediatric immunizations from birth to age 18	You pay nothing	NO COVERAGE

Preventive Care – Notes
1. Preventive care services are consistent with applicable state and federal statutes, regulations, and related guidance. 2. Preventive examinations include a complete medical history, complete physical examination, as well as screening and counseling for obesity, depression, and tobacco cessation.

Preventive Care – Notes

3. Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.
4. Benefits are provided for a full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Please refer to "Prescription Drug Benefits" in the "Benefit Overview" section for outpatient drug coverage.
5. Services for complications related to female contraceptive drugs, devices, and services for women with reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care, "Hospital Outpatient Care, "Office Visit and Professional Services," etc. for appropriate benefit levels.
6. The plan covers: an initial physical examination to confirm pregnancy, folic acid supplement for members planning to become pregnant, counseling for contraceptive methods, counseling and support for breastfeeding, and the purchase of an electric or manual breast pump, or rental charges for a hospital-grade breast pump, and breast pump supplies.
7. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. when services are for: complications or an illness/injury diagnosed as a result of preventive care services, or preventive care services in excess of applicable state and federal preventive recommendations and criteria.
8. Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
    a. diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
    b. diagnostic imaging screening services such as barium enema
    c. surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
    d. such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer.

Reconstructive Surgery

The Plan Covers:	In-network Providers	Out-of-network Providers
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider. • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Reconstructive Surgery – Notes
1. If more than one (1) surgical procedure is performed by the same provider during the same operation, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care. 2. Congenital means present at birth. 3. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

Reconstructive Surgery – Not Covered
1. Repairs of scars and blemishes on skin surfaces. 2. Dentures, regardless of the cause or condition, and any associated services including bone grafts. 3. Dental implants and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19.

Skilled Nursing Facility Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible

Skilled Nursing Facility Care – Notes
1. Skilled care ordered by a physician includes skilled care ordered by an advanced practice nurse or physician assistant when ordered within the scope of their licensure. 2. Coverage is limited to a maximum benefit of 120 days per person per calendar year.

Skilled Nursing Facility Care – Not Covered
1. Custodial care. 2. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care. 3. Services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience. 4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Transplant

The Plan Covers:	In-network Providers	Out-of-network Providers
• Bone marrow/stem cell • Heart • Heart-lung • Liver • Liver-kidney • Lung	You pay nothing of the transplant payment allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	You pay 20% coinsurance of the transplant payment allowance when you use a participating transplant provider NO COVERAGE when you use a nonparticipating provider

Transplant – Notes

1. Prior authorization must be obtained before a transplant procedure.
2. The donor's medical expenses directly related to the organ donation are covered under the recipient's plan. Treatment of any medical complications that occur to the donor are not covered under the recipient's plan.
3. Eligible transplants not performed in conjunction with a major organ transplant noted above are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," and "Office Visit and Professional Services." 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.
4. BDCT facilities have a contract with the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to provide transplant procedures. These facilities have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Facilities are reevaluated regularly to ensure that they continue to meet the established criteria to participate in this network.
5. Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) provider level of benefits when the transplant services are not available at a BDCT provider.
6. If you live more than 50 miles from a BDCT provider, there may be a benefit available for travel expenses directly related to a preauthorized transplant.

Transplant – Not Covered

1. Services for or related to surgical implantation of nonhuman or mechanical devices that serve as a human organ. An exception is the surgical implantation of FDA-approved Ventricular Assist Devices (VAD) to serve as a temporary bridge to a heart transplant.
2. Benefits for travel expenses when you are using a Non-BDCT provider.
3. Transplant services you receive from a nonparticipating provider.

General Exclusions

Except as specifically provided in this health plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "Not Covered" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Services which are not medically necessary and appropriate based on the definition of “medically necessary and appropriate” in “Terms You Should Know.”
2. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
3. Services that are prohibited by law or regulation.
4. Services rendered prior to your effective date of coverage.
5. Services incurred after the date of termination of your coverage, except as provided herein.
6. Services for dependents if you have employee-only coverage.
7. Services that are provided without charge, including services of the clergy.
8. Services rendered by a provider who is a member of your immediate family.
9. Services that are not within the scope of licensure or certification of a provider.
10. Services from providers who are not health care providers.
11. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
12. Custodial care, nonskilled care, adult daycare or personal care attendants.
13. Services for or related to care that can be provided by a non-skilled caregiver who has been trained or is capable of being trained.
14. Room and board for outpatient services.
15. Services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein.
16. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
17. Physical examinations for the sole purpose of obtaining/maintaining employment, insurance, licensing, certification, or physicals for school, camp, or sports.
18. Services for or related to adult preventive vision examinations.
19. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
20. Services for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toenails (except surgery for ingrown toenails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
21. Services, testing, equipment, devices, technologies and supplies purchased or available over-the-counter, whether or not prescribed by a health care provider, unless covered under preventive care.
22. Services for or related to treatment leading to or in connection with sex transformation/gender affirming surgery, sex hormones related to surgery, related preparation and follow-up treatment, care, and counseling.
23. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
24. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, except when medically necessary and appropriate and provided by an eligible health care provider.

25. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.
26. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health plan and you elect this coverage as primary.
27. Charges for the covered patient's failure to keep a scheduled visit.
28. Charges billed by your provider for the completion of a claim form.
29. Any other medical or dental service or treatment or prescription drug, except as provided herein.
30. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
31. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
32. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
33. Services which are not prescribed by or performed by or upon the direction of a professional provider.
34. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
35. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat the member's illness, injury, or disease.
36. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
37. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
38. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
39. Tobacco cessation drugs and products without a prescription.
40. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
41. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
42. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that they will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
43. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; spas; etc., and all related material and products for these programs.
44. Services for furnishing medical records or reports and associated delivery services.
45. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.

46. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.
47. Services for or related to therapeutic massage.
48. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm, except as provided herein.
49. Charges for donor ova or sperm.
50. Services for or related to preservation, storage, and thawing of human tissue, including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue.
51. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
52. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
53. Services and fees for or related to health clubs and spas.
54. Services for or related to the repair of scars and blemishes on skin surfaces.
55. Services for hippotherapy (equine movement therapy).
56. Maintenance services unless part of a specialized therapy for the member’s condition.
57. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
58. Services primarily educational in nature, except as provided herein.
59. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
60. Services for or related to gene therapy or cellular therapy until they have been evaluated by the claims administrator and deemed eligible for coverage.
61. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community, including but not limited to, homeopathy, naturopathy, and reiki.
62. Charges for chelation therapy, except when medically necessary and appropriate.
63. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
64. Investigative or non-FDA approved drugs, except as provided by law.
65. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or health outcomes.
66. Prescription drugs including, but not limited to, biological products, biosimilars, and gene or cellular therapies, that have an alternative drug available that is similar in safety and effectiveness and is more cost-effective.
67. Solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements, and electrolyte solution, except if administered by tube feeding and as provided in the "Benefit Chart."
68. Charges for therapeutic drugs that can be self-administered.
69. Self-administered drugs that are available for coverage under any applicable pharmacy/prescription drug benefit.
70. Blenderized food, baby food, or regular shelf food when used with an enteral system, or banked breast milk.
71. Infant formula with intact proteins.
72. Any formula (standard and specialized), when used for the convenience of you or your family members.
73. Any non-prescription substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance.

74. Vitamin or dietary supplements, except as provided herein.
75. Charges for food supplements.
76. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
77. Intact protein/protein isolates, including but not limited to, semisynthetic, natural, plant-based, or hydrolyzed, when taken orally (for example, protein powders).
78. Bulk powders, chemicals, ingredients, and products used in prescription drug compounding.
79. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
80. Services for or related to fetal tissue transplantation.
81. Travel expenses for an organ donor.
82. Organ donor expenses for complications incurred after the organ is removed if the donor is not covered under this health plan.
83. Organ donor expenses when the recipient is not covered for the organ transplant under this health plan.
84. Services for or related to the treatment of compulsive gambling.
85. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).

In addition, under your prescription drug benefits, except as specifically provided in this health plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for:

86. Charges for any drugs prescribed for cosmetic purposes only.
87. Over-the-counter drugs, except as provided herein.

Health Care Management

Medical and Behavioral Health Care Management

The claims administrator reviews services to verify that they are medically necessary and appropriate, and that the treatment provided is the proper level of care. The claims administrator's review includes applying medical criteria that may require a provider to submit a treatment plan. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization or admission notification, or emergency admission notification.

Prior authorization and admission notification are required for specific services.

If the care you receive is due to a medical emergency, prior authorization is not required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, no later than two (2) business days, following the admission.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity and appropriateness before a service is rendered. Prior authorization should be obtained before a service is rendered and, if applicable, before additional services are rendered beyond what has previously been approved. The claims administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the claims administrator's medical and behavioral health policies. The claims administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the claims administrator's website at bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

A continued stay review (inpatient) or extension request (outpatient) is a process that involves review of an ongoing service for a member with an existing authorization or an admission notification for acute hospitalization. It includes determining whether the current health care facility is still the most appropriate to provide the level of care required for the patient, or whether continued care is medically necessary. These types of review may also be referred to as "concurrent review."

Participating Providers in Minnesota and Bordering Counties

For services that require prior authorization participating providers in Minnesota and bordering counties are required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges.

The claims administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The claims administrator requires that you or the provider contact them at least 10 business days prior to the provider scheduling the care/services to determine if the services are eligible. The claims administrator will notify you of their decision within 10 business days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The claims administrator will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the claims administrator will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to

determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The claims administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, inform the claims administrator that you will be admitted for inpatient hospitalization or post-acute care services separate from prior authorization. The claims administrator requires that you, or your provider, as determined below, call us at least two (2) days prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency admission notification** is a process whereby the provider, or you, inform the claims administrator of an unplanned or emergency admission, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, when required, the claims administrator will provide a review of medical necessity and appropriateness related to a specific request for care or services. As needed during an admission, the claims administrator will review the continued stay to determine medical necessity and appropriateness and to help you when you are discharged.

You, or your provider, may also be required to obtain prior authorization for the services or procedures done during a hospital stay; for example, an elective surgery that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the claims administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary and appropriate, you are liable for all the charges.

Penalty Provision

If the claims administrator is not notified of your inpatient hospitalization or post-acute care services, separate from prior authorization, a penalty will apply. The claims administrator reduces the allowed amount for the admission by $500. This means that without admission notification you will pay a greater portion of the charges. The penalty applies when the claims administrator is not notified of your admission to nonparticipating providers.

Medical and Behavioral Health Care Management Overview

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

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Participating Provider Outside of Minnesota/ Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

How Your Program Works

Your health plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **in-network** or **out-of-network.**

In-network Care

In-network care is care you receive from providers in the health plan's network.

When you receive health care within the network, you enjoy maximum coverage and maximum convenience. You present your member ID card to the provider who submits your claim.

Out-of-network Care

Out-of-network care is care you receive from providers who are not in-network.

When you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, prior authorization may be required from the claims administrator before services are received. For specific details, please refer to "Health Care Management."

Please note that you may incur significantly higher financial liability when you use nonparticipating providers compared to the cost of receiving care from in-network providers. If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the difference between what the claims administrator would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the claims administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

Out-of-area Care

Your health plan also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield BlueCard PPO network will be covered at the higher level of benefits. If you receive covered non-emergency services from a provider who is not part of the local Blue Cross and Blue Shield BlueCard PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment immediately.

Emergency services will be covered at the higher benefit level. If the treatment results in an admission, please refer to "Health Care Management" for admission notification requirements.

Non-emergency benefits apply to follow-up or scheduled services once your condition has stabilized.

If the illness or injury is not an emergency, services will be paid at the lower, out-of-network level. See “Out-of-network Care” for more information about coverage.

General Provider Payment Methods

This is a general summary of provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary. Please note that some of these payment methodologies may not apply to your particular plan.

Participating Providers

Under the payment arrangements of the participating provider agreements, providers have agreed to provide care and receive the contractual allowed amount as payment in full, less member cost-sharing (e.g., deductible, coinsurance, copays) or amounts paid by other insurance for health services. The allowed amount may vary from one (1) provider to another for the same service. These payment amounts generally result in the provider being paid less overall than its billed charges.

The allowed amount may not include other payment adjustments which may occur periodically including settlements to capture complex claims accurately, settlements for withhold, capitation, outlier cases, fee schedule adjustments, rebates, prospective payments, or other methods. Such adjustments are completed without reprocessing individual

claims. These settlements will not cause any change in the amount members paid at the time of claims processing. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and if the payment to the provider is increased, the claims administrator will pay that cost.

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

Depending upon your health plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health plan. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Professional (i.e., doctor visits, office visits)
  - **Fee-for-Service or Discounted Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on a fee schedule allowance for each service or a percentage of the provider's billed charges.
  - **Withhold and Bonus Payments -** Providers are paid based upon a fee schedule or percentage of billed charges, and a portion is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the care while demonstrating the optimal treatment for patients.
  - **Capitation Payments –** Providers may be paid in part based upon a per person per month capitation amount. This amount is calculated based upon historical costs and volumes to determine the average costs for providing medically necessary care to a patient.
- Institutional (i.e., hospital and other facility provider)
  - Inpatient care
    - **Payments for each Case (case rate) or for each day (per diem) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission in a hospital facility.
    - **Percentage of Billed Charges -** Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient services.
    - **DRG Payments –** All Patient Refined Diagnosis Related Groups (APR DRG) or other DRG payments apply to most inpatient claims. DRG payments are based upon the full range of services the patient typically receives to treat the condition.
  - Outpatient care
    - **Enhanced Ambulatory Patient Groupings (EAPG) –** Used for payment on most outpatient claims. EAPG payments are based upon the full range of services the patient typically receives to treat the condition.
    - **Payments for each Category of Services -** Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - **Payments for each visit -** Providers are paid a fixed or bundled amount for all related services a member receives during one (1) visit.
    - **Percentage of Billed Charges –** Providers are paid a percentage of their regular billed charges for services.
- Special Incentive Payments

  As an incentive to promote high quality, cost-effective care and to recognize those providers that participate in certain quality improvement projects, providers may be paid extra amounts based on the quality of the care and on savings that the provider may generate through cost effective care. Certain providers also may be paid in advance in recognition of their efficiency in managing the total cost of providing high quality care and implementing programs such as care coordination. Quality is measured against adherence to recognized quality criteria and improvement such as optimal diabetes care, supporting tobacco cessation, cancer screenings, and other services. Cost of care is based on quantifiable criteria to demonstrate managing claims costs. These quality and cost incentives are not reflected in claims payment.

- Pharmacy Payment

  Generally, four (4) types of pricing are compared and the lowest amount is paid the:

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

Nonparticipating Providers

A nonparticipating provider does not have any agreement with the claims administrator or another Blue Cross and/or Blue Shield plan. Nonparticipating providers are not credentialed or subject to the requirements of a participating agreement.

The allowed amount for a nonparticipating provider is not the amount billed and is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the billed charge. Members are responsible to pay the difference between the claims administrator's allowed amount and the nonparticipating provider's billed charge, except as described in "Special Circumstances." This amount can be significant and does not count toward any out-of-pocket limit contained in the plan.

Payment for covered services provided by a nonparticipating provider will be made at the out-of-network level. Please refer to "Out-of-network Care" and "In-network Care" for additional detail on covered services received in-network and out-of-network.

Example

The following illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health plan covers 80% for participating providers and 60% for nonparticipating providers.

	Participating Provider	Nonparticipating Provider
Provider charge:	$150	$150
Allowed amount:	$100	$80
Claims administrator pays:	80% ($80)	60% ($48)
Coinsurance you owe:	20% ($20)	40% ($32)
Difference up to billed charge you owe:	None	$70 ($150 minus $80)
You pay:	$20	$102

Special Circumstances

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

What is "balance billing" (sometimes called "surprise billing")?

Nonparticipating providers and facilities that have not signed a contract with your health plan may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by a nonparticipating provider.

Your Rights and Protections Against Surprise Medical Bills

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. These circumstances could include nonparticipating providers in an in-network hospital, your in-network physician using a nonparticipating laboratory, post-stabilization following emergency services, or medically necessary air ambulance services.

When you get emergency care or get treated by a nonparticipating provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum.

When a claim is identified as a special circumstance, payment will be made to the nonparticipating provider when required by law. These nonparticipating providers can negotiate with the claims administrator for a higher allowed amount after the initial payment has been made. This may result in an increase to the amount applied to your in-network cost-sharing. For additional information, you can contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's website at bluecrossmn.com.

You are protected from balance billing for:

- Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers may be nonparticipating providers. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.
- Emergency services - If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Surprise Air Ambulance Bills – Emergency air ambulance transportation that is provided to you by nonparticipating providers will be reimbursed at in-network cost-sharing rates. Nonparticipating air ambulance providers cannot balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum. Please refer to "Ambulance" for coverage of benefits.

Steps You Can Take

If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the services, this could be a "surprise" or "balance" bill. If you have questions regarding what a "surprise" or "balance" bill is, call customer service at the number on the back of your ID card or visit the claims administrator's website at bluecrossmn.com. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law, please refer to "Emergency Care" for coverage of benefits. You may appeal a decision that your claim does not qualify as a special circumstance. Please refer to "Appeal Process."

Women's Health and Cancer Rights Act

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

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Coverage may be subject to annual deductible, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one (1) sex, to a transgender individual because of the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the claims administrator's applicable medical and behavioral health policies and/or federal law.

Inter-Plan Arrangements

Out-of-area Services

The claims administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area the claims administrator serves, the claim for those services may be processed through one (1) of these inter-plan arrangements. The inter-plan arrangements are described below.

Plan Arrangements

When you receive care outside of the claims administrator's service area, you will receive it from one (1) of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The claims administrator explains below how the claims administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the claims administrator will remain responsible for doing what the claims administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the claims administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or
- the negotiated price that the Host Blue makes available to the claims administrator.

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the claims administrator has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claims administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the claims administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

When covered health care services are provided outside of the claims administrator's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the claims administrator will make for the covered health care services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global® Core

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services. **You must contact the claims administrator to obtain approval for non-emergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Out-of-country Benefits

Eligible services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the network level of coverage.

Call the Blue Cross Blue Shield Global Core service center within 24 hours of a medical emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global Core service center or services are not eligible under this program, eligible services will process at the out-of-network level of benefits.

Services not covered under the plan will not be considered for benefits.

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the health plan service area.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. The claims administrator considers educational background, office procedures and performance history to determine eligibility. Then the claims administrator monitors care on an ongoing basis through office record reviews and member satisfaction surveys.

Please note that while you or a family member can use the services of any in-network physician or specialist without a referral and receive the maximum coverage under your health plan, you are encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive in-network care. You may want to double-check any provider recommendations to make sure the doctor or facility provider is in-network. Your provider directory lists in-network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is an in-network provider for your particular plan. Not every provider is an in-network provider for every plan. For a list of providers in the directory, visit bluecrossmn.com ("Member Log in" then "Find a Doctor") or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

How to Get Your Physicians' Professional Qualifications

To view Board Certification information, hospital affiliation or other professional qualifications of your provider, visit your member website at bluecrossmn.com, or contact customer service at the telephone number listed on the back of your member ID card.

In-network Pharmacies

- **Retail Pharmacy:** Participating retail pharmacies have an arrangement with the claims administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered prescription drugs from an in-network pharmacy applicable to your health plan, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by telephone from your physician or dentist may also be covered.) You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

  If you travel within the United States and need to refill a prescription, contact customer service at the telephone number listed on the back of your member ID card for help. They can help you find an in-network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the in-network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **90dayRx:** 90dayRx Pharmacy includes 90dayRx participating retail pharmacy and/or a mail service pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing, long-term basis.
  - To utilize a 90dayRx participating retail pharmacy, verify that your pharmacy participates in the network and present your prescription for a 90-day fill of the eligible prescription medication.
  - For more information on how to use a mail service pharmacy log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.

- **Specialty Pharmacy In-network Supplier:** The specialty pharmacy in-network supplier has an agreement, with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you. Please refer to "Specialty Drugs" in "Terms You Should Know" for a list of the selected specialty prescription drug categories.

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to the claims administrator, this section applies to you. If you are currently receiving care from an out-of-network physician or specialist, you may request to continue to receive care from this physician for a special medical need or condition for a reasonable period of time before transferring to an in-network physician as required under the terms of your coverage under the health plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that speaks a language other than English.

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

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

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

Continuity of Care does not apply to services that are not covered under the health plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) plan to another.

Provider Termination for Cause

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

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the claims administrator ends, rendering your clinic or provider out-of-network, and the termination was by the claims administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to a participating provider as required under the terms of your coverage under the health plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or

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

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

Continuation for members who are undergoing treatment within the first trimester of pregnancy is up to 90 days of coverage.

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

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

Continuity of Care does not apply to services that are not covered under the health plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) plan to another.

Provider Termination for Cause

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

General Information

Plan Administration

Plan Administrator

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

Powers and Duties of the Plan Administrator

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

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

Actions of the Plan Administrator

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

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

Nondiscrimination

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

Time Periods

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

Termination or Changes to the Plan

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

The employer reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the health plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which they have become entitled under the health plan. Any amendment to this health plan may be affected by a written resolution adopted by the plan administrator. The plan administrator will communicate any adopted changes to the employees.

Funding

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

Controlling Law

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

Fraudulent Practices

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

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator or the plan administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount relating to in-network provider, out-of-network participating provider, or nonparticipating provider services. Claim reprocessing may result in changes to the amount paid at the time your claim was originally processed.

Medicare End Stage Renal Disease Program Registration

For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.

Charges That Are Your Responsibility

In-network Providers

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

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

Out-of-network Providers

Out-of-network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the claims administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the claims administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the claims administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the claims administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;

4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full, except as described in "Special Circumstances." This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the claims administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

Medical and Behavioral Health Policy Committee and Medical Policies

The claims administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the claims administrator's Medical and Behavioral Health Policy Committee, which consists of independent community physicians who represent a variety of specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the claims administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new policies may be created or existing policies may change. Covered benefits will be determined in accordance with the policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical and behavioral health policies can be found at the member website. All medical and behavioral health policies are available upon request.

Who is Eligible

You are eligible to participate in the Plan if your company offers the Plan (e.g., Participating Affiliate), you continuously meet the requirements outlined in the attached Employer Eligibility and Participation Provisions, and you are employed by a Participating Affiliate on the date coverage commences. Employees who are covered by a collectively bargained agreement which has not bargained for the Plan are not eligible to participate in the Plan. (Refer to Appendix I.)

Appendix I provides when your participation in the Plan begins based on the company where you are employed. If the company imposes a waiting period, you shall become eligible once you have satisfied the conditions of the waiting period. If you transfer to a company that does not have a waiting period, you shall become eligible for coverage on the date your employment begins with your new company. If you transfer from a company that does not have a waiting period to a company that does have a waiting period, the waiting period will be waived and you will eligible for coverage on the date your employment begins with your new company. If you transfer from a company that imposes a waiting period to a new company that also imposes a waiting period, if you had not previously satisfied the waiting period with the old company, you shall be given a service credit from the old company and that service credit will reduce the waiting period imposed by the new company. If you had already satisfied the conditions of the waiting period with the previous company, the waiting period with the new company shall be waived and you shall become eligible for coverage on the date your employment begins with the new company.

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

Eligible Dependents

NOTE: Any employee who is considered a dependent of another employee within the Knife River Corporation family of companies can enroll in their own contract. However, an employee with their own contract cannot be a dependent on another employee's contract, nor can children be listed on both contracts.

Spouse

Spouse, meaning a person who is legally married to or legally separated from the employee. You may also cover your civil union partner in states which have a formal process for recognizing civil unions. Contact your Human Resources department for more information. US citizenship/residency is required.

Dependent Children

- Natural-born dependent children or stepchildren to age 26.
- Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
- Dependent children for whom you or your spouse have been appointed legal guardian to age 26.
- Foster children placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.
- Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.
- US citizenship/residency is required.

A Dependent child's coverage automatically terminates and all benefits hereunder cease at the end of the month the Dependent reaches the limiting age or ceases to be a Dependent as indicated above, whether or not notice to terminate is received by the Claims Administrator.

Disabled Dependent Children

Disabled Dependent children who reach the Dependent child age limit specified in the "Benefit Summary" while covered under this health care Plan if all of the following apply:

- chiefly Dependent upon the employee for support and maintenance; and,
- incapable of self-sustaining employment because of developmental disability, Mental Illness or disorder, or physical disability; and,
- for whom application for extended coverage as a disabled Dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and,
- must have become disabled prior to reaching the limiting age.

Effective Date of Coverage

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

Adding New Employees

1. If the Plan Administrator receives your application within 31 days after you become eligible, refer to the Employer Eligibility and Participation Provisions (Appendix I).

2. If the Plan Administrator receives your application more than 31 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual open enrollment unless you meet the requirements of the special enrollment period.

Adding New Dependents

Adding a Spouse and/or Stepchildren

1. If the Plan Administrator receives the application within 31 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

2. If the Plan Administrator receives your application more than 31 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual open enrollment unless you meet the requirements of the special enrollment period.

Adding Newborns, Children Placed for Adoption or Foster Care, and Court Ordered Dependents

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

Adding Disabled Dependents

This section outlines the time period for application and the date coverage starts.
If coverage is sought pursuant to a child support order or other order to provide coverage, coverage may be effective as of the date of the court order.

1. If the Plan Administrator receives the application within 31 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

2. If the Plan Administrator receives the application more than 31 days after the date of marriage, your spouse and/or stepchildren must reapply for coverage at the next annual open enrollment unless your spouse and/or stepchildren meet the requirements of the special enrollment period.

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

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

5. A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Administrator receives the application. A disabled dependent will not be denied coverage and will not be subject to any preexisting condition limitation period.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll, the eligible employee or dependent **must notify the claims administrator within 30 days** of the triggering event, unless otherwise noted below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission): • loss of eligibility for employer-sponsored coverage • plan no longer offers benefits • termination of all employer contributions • termination of employment or reduction in hours • legal separation or divorce • loss of dependent child status • death of employee • move outside HMO or ACO service area • exceeding the plan's lifetime maximum • employer bankruptcy • COBRA exhaustion • employee becomes entitled to Medicare

Special Enrollment Triggering Event
Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a dependent due to marriage.
Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.
An individual who loses or gains eligibility for medical assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the claims administrator within 60 days.
Child support order or other court order to provide coverage.

Changes in Membership Status

For the health plan to administer consistent coverage for you and your dependents, you must keep your Employee Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Leave of Absence or Layoff

Upon your return to work following a leave of absence or layoff that continued beyond the period of your coverage, your employer may, in some cases, allow you to resume your coverage. You should consult with your plan administrator/employer to determine whether your group health plan has adopted such a policy.

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the health plan terminates.
2. For you and your dependents, the last day of the month:
    a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the claims administrator receives full payment when due. If the claims administrator terminates coverage for all employees in the health plan for nonpayment of the charges, the claims administrator will give all employees a 30-day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
    b. you are no longer eligible.
    c. you enter military service for duty lasting more than 31 days.
    d. you request that coverage be terminated.
    e. you retire.

Extension of Benefits

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the claims administrator, the health plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the administrative service agreement with the claims administrator has been terminated and your employer maintains continuous group coverage with a new claims administrator or insurer.

Continuation of Coverage

Generally, continuation coverage is the same coverage that you or your covered dependents had on the day before the qualifying event. You have the same rights under this plan as active employees or their dependents.

Qualifying Events

You or your covered dependents may continue this coverage if it ends because of one (1) of the qualifying events listed below. You and your eligible dependents must be covered on the day before the qualifying event in order to continue coverage.

NOTE: You may have a right to special enrollment in a new plan, such as another employer plan.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct.	Employee and dependents	• 18 months from the first of the month following the event, or • Enrollment date in other group coverage.
Reduction in hours	Due to lay-off, leave of absence, strike, lockout, change from full-time to part-time employment.	Employee and dependents	• 18 months from the first of the month following the event, or • Enrollment date in other group coverage.
Death of employee		Dependents	• 36 months from the date of the employee's death, • Enrollment date in other group coverage, or • Date coverage would otherwise end if the employee had lived.
Employee becomes enrolled in Medicare		Dependents	• 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end.
Divorce or legal separation	• Spouse/ex-spouse who was covered on the day before the entry of the valid decree of dissolution of marriage. • If coverage for spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event.	Spouse/ex-spouse and any dependent children who lose coverage	• 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Dependent child is no longer eligible		Dependent child	• 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end.
Employer filing Chapter 11 bankruptcy	• You are a retiree of the employer filing Chapter 11 bankruptcy. • Includes substantial reduction in hours within one (1) year of filing.	Retiree	• Lifetime continuation.
		Dependents	• Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
		Surviving spouse	• Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death. • Lifetime continuation when retiree is deceased at time of event and spouse is already covered by the plan.

Qualifying Event Extensions

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

Total Disability of Dependents

- You have continuation coverage because the employee was terminated from employment or had a reduction of hours, and
- The disability occurs prior to the end of the initial 18-month continuation period, and
- Social Security Administration (SSA) determines a dependent covered under the initial continuation coverage is disabled at any time during the first 60 days of continuation.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 29-month from the date the employee leaves employment or until the date total disability ends or the date coverage would otherwise end, whichever comes first.

Second Qualifying Event

- You have continuation coverage because the employee was terminated or had a reduction of hours, and
- The second qualifying event occurs prior to the end of the original 18-month continuation period or 29-month disability extension, and
- The second qualifying event has at least a 36-month continuation period.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 36 months from the date of the initial event or the enrollment date in other group coverage or the date coverage would otherwise end, whichever comes first.

Certain qualifying events allow lifetime continuation, refer to the Qualifying Event table above.

Employee Enrolled in Medicare

- Employee is enrolled in Medicare, and
- Later experiences termination of employment or a reduction of hours worked, and
- This occurs within 18 months after the date of the employee's Medicare enrollment.

Dependents may extend coverage for maximum period of 36 months from the date of the event or the enrollment date in other group coverage or the date coverage would otherwise end, whichever comes first.

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty, the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Employee and dependents may extend coverage for a maximum period of 24 months.

Continuation Notice Obligations

You or your dependents each are entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage.

In addition, a dependent may elect continuation coverage even if the covered employee does not elect continuation coverage.

If your or your dependent's address changes, you must notify the employer in writing so the employer may mail you or your dependent important continuation notices and other information.

Contact the employer to determine how to elect continuation coverage.

Notices for	Employee/Dependent	Employer	Eligible Employee/Dependent
Coverage termination due to: • Termination of employment • Reduction in hours • Death of the employee • Employee becomes enrolled in Medicare	Notice must be provided to employer within 60 days of the event if the employer is not aware of the event.	Send the qualifying event notice to eligible individuals within 14 days of the event or upon receipt of notice to advise: • of the right to elect continuation coverage or • when continuation is not available and why.	Elect continuation coverage within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.

Notices for	Employee/Dependent	Employer	Eligible Employee/Dependent
Coverage termination due to: • Divorce or legal separation • Dependent child is no longer eligible	• Notice must be provided to employer within 60 days of the event. • Notice must be provided to employer within 60 days after a later divorce or legal separation when coverage was earlier terminated in anticipation of the divorce or legal separation.	Upon receipt of notice, notify the eligible individuals: • of the right to elect continuation coverage or • when continuation is not available and why.	Elect continuation within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.
Extension of continuation due to: • Disability determination or • New qualifying event	Notice must be provided: • to employer within 60 days of the disability determination or new event and • before the end of the initial 18-month or 29-month continuation period.	Upon receipt of notice: • notify the eligible individuals of the right to elect continuation coverage, or • notify you when an extension is not available and why.	Elect continuation within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the employee and dependents will automatically terminate when any one (1) of the following events occur:

- The employer no longer provides group health coverage to any of its employees.
- The premium for continuation coverage is not paid when due.
- If during an 18-month or 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the employer within 30 days of the final determination.
- After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered employees or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

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

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee.

In the event of a dependent's disability, the premiums for continuation for the employee and dependents can be up to 150 percent of the group rate for months 19-29 if the disabled dependent is covered.

All premiums are paid directly to the employer.

Coordination of Benefits

Most health plans, including this plan, contain a coordination of benefits (COB) provision. The COB provision is used when you, your spouse, or your covered dependents received a health care service and had active benefits under more than one (1) plan at the time of that service.

When you have health care coverage under more than one (1) plan, benefits will be coordinated. The “Order of Benefits Rules” determines which plan provides benefits first. Your benefits under this plan are not reduced if the rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

Coordination of benefits is to ensure that your covered expenses will be processed, while ensuring that the claim charges are not overpaid. If you receive funds to pay a provider directly, and you receive more funds than you should have, you will be expected to repay any overpayment.

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; or
   c. individual coverage.

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

   "Plan" does not include hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

   Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.
2. "This plan" means the part of the plan document that provides health care benefits.
3. "Primary plan/secondary plan" means the Order of Benefits Rules establishing whether this plan is the primary plan or secondary plan when compared to the other plan covering the person.

   When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When you are covered under more than two (2) plans, this plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.
4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare.

   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.

Order of Benefits Rules

This plan uses the following rules to establish which plan is the primary plan:

You and Your Dependents

1. When your other plan does not include order of benefit rules, then that plan is the primary plan.
2. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is the primary plan over the plan that covers the member as a dependent.

Dependent Children

1. Birthday Rule
   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
   b. If both parents have the same birthday, the plan that covered the parent longer is the primary plan.
2. Separated or Divorced Parents
   a. The plan of the parent with custody of the child is the primary plan.
   b. The plan of the spouse of the parent with custody is the secondary plan.
   c. When a court decree specifies the parent who is financially responsible for the child's health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of that parent is the primary plan. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

Other

The plan of an individual who is covered as an employee is the primary plan over the plan of an individual who is either laid-off or retired.

When the member who received care is covered under the No-Fault Automobile Insurance Act or similar law or traditional automobile "fault" type coverage, that coverage applies benefits first.

When none of these circumstances applies, the plan that has continuously covered the individual for the longest time is the primary plan.

Medicare and TRICARE

This plan will comply with the Medicare Secondary Payor (MSP) and TRICARE provisions of federal law to determine which plan is a primary plan and which is a secondary plan.

Medicare or TRICARE will be primary and this plan will be secondary only to the extent permitted by MSP or TRICARE rules.

When Medicare or TRICARE is the primary plan, this plan will coordinate benefits up to Medicare's or TRICARE's allowed amount.

Effect on Benefits of This Health Plan

When this section applies:

1. When the Order of Benefits Rules require this health plan to be a secondary plan, this part applies. Benefits of this health plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:

   The benefits that would be payable under this health plan without applying coordination of benefits are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under this health plan. This applies whether or not claim is made under a plan.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable. When benefits of this health plan are reduced each benefit is reduced in proportion to any applicable benefit limit, such as the deductible, of this health plan.

Right to Receive and Release Needed Information

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

Facility of Payment and Right of Recovery

When another plan pays an amount that should have been paid under this plan, this plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this plan. This plan will not have to pay that amount again. If this plan pays more than it should have paid under these coordination of benefit rules, this plan may recover the excess from any of the following:

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

Any payment made or amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

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

The Health plan's Right of Subrogation

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

Obligation to Reimburse the Health plan

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

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

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

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

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

Duty to Cooperate

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

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

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

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

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

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement,** as required by the health plan and provide any other information

required by the health plan. A violation of the reimbursement agreement is considered a violation of the terms of the health plan.

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

Attorney's Fees and Other Expenses You Incur

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

The plan administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the claims administrator.

What May Happen to Your Future Benefits

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

Interpretation

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

How to File a Claim

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

Types of Claims

A "claim" is any request for a plan benefit made in accordance with these claims procedures. You become a "claimant" when you make a request for a plan benefit in accordance with these claims procedures. There are four (4) types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

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

Urgent Care Claim

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

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

Concurrent Care Claim

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

Post-Service Claim

A "post-service claim" is any request for a plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

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

Filing Claims

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for plan benefits to the claims administrator. A claimant is not responsible for submitting claims for services received from in-network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the claims administrator. The necessary forms may be obtained by contacting the claims administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the claims administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the claims administrator by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the claims administrator.

Post-Service Claims

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

Incorrectly Filed Claims

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

Timeframes for Deciding Claims

Urgent Care Claims

The claims administrator will decide an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The claims administrator will decide a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

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

Concurrent Care Reduction or Early Termination

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

Post-Service Claims

The claims administrator will decide a post-service claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

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

Incomplete Claims

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

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

Notification of Initial Benefit Decision

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

Right of Examination

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

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The claims administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The claims administrator will give no deference to the initial benefit decision;
6. The claims administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
7. The claims administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The claims administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the claims administrator did not rely upon their advice;
9. The claims administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the claims administrator;
10. The claims administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The claims administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The claims administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the plan administrator.

Filing Appeals

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

Urgent Care Appeals

An urgent care appeal may be submitted to the claims administrator by telephone at 1-866-873-5943. The claims administrator will transmit all necessary information, including the claims administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The claims administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The claims administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The claims administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The claims administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Appeal Process

Notification of Appeal Decision

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

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

Voluntary Appeals

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

External Review

Standard External Review

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

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

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

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

   The IRO will review all of the information and documents timely received and is not bound by the claims administrator's prior determination. The IRO may consider the following in reaching a decision:
   a. your medical records;
   b. the attending health care professional's recommendation;
   c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
   d. the terms of the plan;
   e. evidence-based practice guidelines;

f. any applicable clinical review criteria developed and used by the claims administrator; and
g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

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

Expedited External Review

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

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

Additional Provisions

Authorized Representative

A claimant may appoint an "authorized representative" to act on their behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the claims administrator. However, in connection with an urgent care claim, the claims administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the claims administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity their right to legally challenge any decision, action, or inaction of the claims administrator.

Claims Payment

When a claimant uses in-network or out-of-network participating providers, the plan pays the provider. When a claimant uses a nonparticipating provider, the plan pays the claimant. A claimant may not assign their benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the plan pay a nonparticipating provider for covered services for a child. When the plan pays the provider at the request of the custodial parent, the plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the claims administrator.

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

No Third Party Beneficiaries

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

Release of Records

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

Right of Examination

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

Privacy of Protected Health Information

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

Restrictions on the Use and Disclosure of Protected Health Information

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

Separation Between the Employer and the Plan

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

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

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

Employee Retirement Income Security Act (ERISA) Statement of Rights

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the plan on the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

Important Plan Information

Plan name:	Knife River Corporation Health and Welfare Benefits Program
Type of plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
ERISA plan year:	January 1st through December 31st
Plan number:	501
Funding medium:	This plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contribution toward the cost of coverage under the plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The claims administrator's payment of claims is contingent upon the plan administrator continuing to provide sufficient funds for benefits. The Company's practice is to share premium increases with the employee, but is determined by each participating employer; a medical plan's design features may change from time to time and as such, the changes become part of this Company-provided medical plan. Normally, premium adjustments are made effective January 1 of each year, and the required employee contribution is communicated in the fourth quarter of the preceding year.
Type of plan administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the plan and Blue Cross and Blue Shield of Minnesota.
Plan sponsor:	Knife River Corporation 1150 West Century Avenue Bismarck, ND 58503 (701)-530-1416
Plan sponsor's Employer Identification Number:	92-1008893
Plan administrator:	Employee Benefits Committee c/o Corporate Human Resources Knife River Corporation 1150 West Century Avenue Bismarck, ND 58503 (701) 530-1416
Named fiduciary for claims purposes:	Blue Cross

Named fiduciary for all other purposes:	Employee Benefits Committee Knife River Corporation 1150 West Century Avenue Bismarck, ND 58503 (701) 530-1416
Agent for services of legal process:	VP, Chief Legal Officer & Secretary Knife River Corporation 1150 West Century Avenue Bismarck, ND 58503 Service of legal process may also be made on the plan administrator.
Plan document:	The plan and its attachments, if any, constitute the written plan document required by ERISA §402.

Terms You Should Know

90dayRx - Participating 90dayRx mail service and retail pharmacies used for the dispensing of a supply of long-term prescription drug refills.

Accountable Care Organization (ACO) - A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

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

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

Adverse Benefit Determination - A decision relating to a health care service or claim that is partially or wholly adverse to the complainant.

Aftercare/Continuing Care Services - The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.

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 (1) provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." The allowed amount may include the provider's applicable taxes, for example, the MinnesotaCare tax.

The allowed amount for participating providers

For participating providers, the allowed amount is the negotiated amount of payment that the in-network 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 in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, which may include an agreed upon fee schedule rate, case rate, withhold and/or capitation agreements, rebates, prospective payments or other methods, the claims administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not 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, 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.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The claims administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the claims administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the claims administrator's Provider Policy and Procedure Manual. As a result, the claims administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described in “Special Circumstances,” the allowed amount will be based upon one (1) of the following payment options to be determined at the claims administrator’s discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (4) as may be required by federal law. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described in “Special Circumstances,” the allowed amount will be based upon one (1) of the following payment options to be determined at the claims administrator’s discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; (4) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (5) as may be required by federal law. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) - A procedure in which semen is placed in a vagina, cervix, or uterus.

Assisted Reproductive Technology - Treatments or procedures that are done to start a pregnancy. This may include handling eggs and sperm or embryos.

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cellular therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Brand Drug - A recognized trade name prescription drug product, usually either the innovator product for new prescription drugs still under patent protection or a more expensive product marketed under a brand name for multi-source prescription drugs and noted as such in the pharmacy database used by the claims administrator.

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

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.

Care/Case Management Plan - A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

Cellular Therapy - The transfer of cells into a person with the goal of improving a disease. Gene modified cell therapy removes the cells from a person’s body and alters the genetic material of the cell. The modified cells are then reintroduced into the body.

Chronic Condition - Any physical or mental condition that requires long-term monitoring and/or management to control symptoms and to shape the course of the disease.

Claim - A request for prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-service claim -** A request for prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent care claim -** A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending health care provider.
- **Post-service claim -** A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Claims Administrator - Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the billed charge. Because payment amounts are negotiated to achieve overall lower costs, the allowed amount for participating providers is generally 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 us 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 we have 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 calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

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

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

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out-of-pocket costs will be higher as shown in the example above.

Compound Drug - A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solutions are added. The compound drug must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.

Continued Stay - A continuation of inpatient care services for a member with an existing prior authorization. A continued stay review determines if continued inpatient care is medically necessary and/or if the current health care facility is still the most appropriate to provide the level of care required for the patient. Also known as concurrent review.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

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

Covered Drug List - The claims administrator’s designated covered drug list for this plan is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee.

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

Custodial Care - Care provided primarily for maintenance of the member or which is designed essentially to assist the member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Cycle - One (1) partial or complete fertilization attempt extending through the implantation phase only.

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

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your deductible.

Dental Implant - Metal, screwlike posts surgically inserted in the jawbone to replace damaged or missing teeth with artificial teeth that look and function like real ones.

Dependent - Your spouse, child to the dependent child age limit provided in "Who is Eligible," child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit provided in "Who is Eligible,", grandchild who meets the eligibility requirements as provided in "Who is Eligible" to the dependent child age limit provided in "Who is Eligible," disabled dependent or dependent child as provided in " Who is Eligible," or any other person whom state or federal law requires be treated as a dependent under this health coverage.

Designated Agent - An entity that has contracted, either directly or indirectly, with the claims administrator to perform a function and/or service in the administration of this health plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Diabetes Self-Management Education (DSME) - The process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. Diabetes self-management support (DSMS) refers to the support that is required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis. The overall objectives are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. Support can be behavioral, educational, psychosocial, or clinical. DSMES will be provided by one (1) or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one (1) of the instructors will be a registered nurse, dietitian, or pharmacist. DSMES must be consistent with the National Standards for Diabetes Self-Management Education.

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

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

Enrollment Date - The first day of coverage, or if there is a waiting period, the first day of the waiting period (typically the date employment begins).

E-Visit - A member-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established member.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the claims administrator to be medically effective for the condition being treated. The claims administrator will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health plans must evaluate these technologies. The claims administrator believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.

Extended Hours Skilled Nursing Care (Private Duty Nursing) - Extended hours home care are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. Extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

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

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

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

Gene Therapy - The introduction, removal, or change in the content of a person's genetic material with the goal of treating or curing a disease. It includes therapies such as gene transfer, gene modified cell therapy, and gene editing.

Generic Drug - A prescription drug that is available from more than one (1) manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orange Book, and noted as such in the pharmacy database used by the claims administrator.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

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

Health Care Provider - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home Health Agency - A preapproved facility that sends health care 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 inpatient hospital setting for covered individuals diagnosed with a terminal disease or condition.

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

Host Blue - A Blue Cross and/or Blue Shield licensee outside of Minnesota that has contractual relationships with providers in its designated service area that deliver the benefit of its arrangements with its local and ancillary providers eligible for Inter-Plan Programs, on behalf of Control/Home Licensee Members who incur claims within its service area.

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

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between partners for a period of at least 12 months. The inability to conceive may be due to either partner.

In-network - Depending on where you receive services, the in-network is designated as one (1) of the following:

- When you receive services within the health plan service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services within the claims administrator's service area, the designated in-network for professional providers and facility providers is the Aware network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with the claims administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

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

Intermittent Skilled Nursing Care - Services consisting of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.

Lifetime Maximum - The cumulative maximum payable for specified covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health plans with the employer. The lifetime maximum does not include amounts which are the member's responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Mail Service Pharmacy - A pharmacy that dispenses prescription drugs through a home delivery option.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time.

Marriage/Couples Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

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

Medical Emergency - Medically necessary and appropriate 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 member in serious jeopardy.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (iii) not primarily for the convenience of the member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. The claims administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless the claims administrator determines that the service, supply or covered medication is medically necessary and appropriate.

With respect to mental health care services: services appropriate, in terms of type, frequency, level, setting, and duration, to the member’s diagnosis or condition, and diagnostic testing and preventive services. Medically necessary and appropriate care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

(1) help restore or maintain the member’s health; or
(2) prevent deterioration of the member’s condition.

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

Mental Illness - A mental disorder as defined in the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. It does not include substance dependence, nondependent substance use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Opioid Treatment - Treatment that uses Medication Assisted Treatment (MAT) to control withdrawal symptoms of opioid addiction.

Out-of-network Participating Provider - Providers who have a contract with the claims administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-network Provider - A provider with a Blue Cross contract that is not specific to this plan; and nonparticipating providers.

Out-of-pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a licensed mental health care professional for mental health disorders, or a licensed substance use professional for substance use disorders.

Outpatient Care - Services received without being admitted for an inpatient stay. Services received at an ambulatory surgery center are considered outpatient care.

Palliative Care - Services specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services are focused on improving quality of life by enabling a patient to address social, emotional and spiritual needs, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Partial Programs - An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.

Participating Pharmacy - A pharmaceutical provider that participates in a network for the dispensing of prescription drugs.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Physician - A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of Service - Clinic and hospital providers submit claims using national standards established by the Centers for Medicare & Medicaid Services (CMS) and state guidelines. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.

Plan - The plan of benefits established by the plan administrator.

Plan Year - A 12-month period which begins on the effective date of the plan and each succeeding 12-month period thereafter.

Preferred Drug List - The claims administrator’s preferred drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator’s Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.

Prescription Drugs - Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health provider who is authorized by law to prescribe the drug.

Provider - A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes home/suite infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rehabilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A facility licensed under state law in the state in which it is located that provides residential treatment under the direction of, a licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day.

Respite Care - Short-term inpatient or home care provided when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold).

Retail Pharmacy - Any licensed pharmacy that you can physically enter to obtain a prescription drug.

Self-Administered Drugs - Drugs you would normally take on your own. These drugs do not require direct supervision or administration by a health care provider, regardless of whether initial medical supervision or training is required.

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

Skilled Care - Services rendered that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care provider. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed health care provider. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed health care provider, shall not be regarded as skilled care, whether or not a licensed health care provider actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed health care provider provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

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

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing their illness, treatment, and the requirements of everyday independent living.

Specialist/Specialist Physician - A physician who limits their practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, drugs in specific categories or drug classes. If your health care provider prescribes one (1) of these drugs, there must be documented evidence that you have tried another

eligible drug(s) that is safe, more clinically effective, and in some cases more cost-effective before the drugs subject to step therapy medication will be paid under the drug benefit.

Substance Use Disorder and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Supervised Employees - Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S., or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supplies - Health care materials prescribed by a physician that are not reusable. They are used primarily for a medical purpose and are generally not useful in the absence of illness or injury.

Supplies include, but are not limited to:
1. ostomy supplies;
2. catheters;
3. oxygen; and
4. diabetic supplies.

Surrogate Pregnancy - An arrangement in which a person agrees to carry a pregnancy for another person.

Telehealth Services - The delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a member's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a member located at an originating site and a provider located at a distant site. Originating site means a site where the member is located at the time health care services are provided to the member by means of telehealth. Coverage is provided for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Telehealth does not include communication between providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a provider and a member that consists solely of an e-mail or facsimile transmission.

Tobacco Cessation Drugs and Products - Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

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

Value-Based Program - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one (1) or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

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

The Blue Cross® and Blue Shield® Association is an association of independent Blue Cross and Blue Shield plans.

You are hereby notified, your health care benefit program is between the employer, on behalf of itself and its employees and Blue Cross and Blue Shield of Minnesota. Blue Cross is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Blue Cross Blue Shield shall be liable to the employer, on behalf of itself and its employees, for any Blue Cross Blue Shield obligations under your health care benefit program.

2024 EMPLOYER ELIGIBILITY AND PARTICIPATION PROVISIONS

See Eligibility Section for further information

Participating affiliates *(dba/administrative name):*

Anchorage Sand and Gravel Company, Inc.
Baldwin Contracting Company, Inc. (*dba Knife River Construction – Northern California Chico Division*)
Concrete, Inc. *(dba Knife River – Northern California Ready Mix Division)*
Connolly-Pacific Co.
DSS Company *(dba Knife River Construction – Northern California Stockton Division)*
Ellis & Eastern Company
Fairbanks Materials, Inc.
Granite City Ready Mix, Inc. *(dba Knife River Materials – Central Minnesota Division)*
Jebro Incorporated
Kent's Oil Service *(dba Pacific Northwest Oil)*
KRC Materials, Inc.
Knife River Corporation - Mountain West
Knife River Corporation - North Central *(dba Knife River – Central Minnesota Division)*
Knife River Corporation - North Central *(dba Knife River – ND Division)*
Knife River Corporation - Northwest *(KRO)*
Knife River Corporation - South
Knife River Midwest, LLC
LTM, Incorporated *(dba Knife River Materials – Southern Oregon Division)*
Northstar Materials, Inc. *(dba Knife River Materials – Northern Minnesota Division)*
Rail to Road, Inc.
Sweetman Const. Co.

KNIFE RIVER CORPORATION AND DIVISIONS		
	ELIGIBILITY REQUIREMENT*	**WHEN PARTICIPATION BEGINS**
• KRC Materials, Inc. • Anchorage Sand and Gravel Company, Inc • Baldwin Contracting Company, Inc. (dba KR Const – N CA – Chico Division) • Concrete, Inc. (dba KR – N CA Ready Mix Division) • Connolly-Pacific Co. • DSS Company (dba KR Const – N CA Stockton Division • Ellis & Eastern Company • Fairbanks Materials, Inc. • Granite City Ready Mix, Inc. – (dba KR Materials – Central Minnesota Division) • Jebro Incorporated • Kent's Oil Service, Inc. (dba Pacific Northwest Oil) • Knife River Corporation – Mountain West • Knife River Corporation North Central – (KR – Central MN Division) • Knife River Corporation North Central – (dba KR – ND Division) • Knife River Corporation – Northwest (KRO) • Knife River Corporation – South • Knife River Midwest, LLC • LTM, Incorporated (dba KR Materials – Southern Oregon Division) • Northstar Materials, Inc. (dba KR Materials – No. MN Division) • Rail to Road, Inc. • Sweetman Const. Co.	30 hours per week	The first of the month following 30 days

*You may also be eligible for medical coverage if, taking into account actual hours worked or hours for which you are entitled to payment, you work an average of 30 hours per week during the annual required testing period (11/1-10/31 for all participating companies) of any given year or during the 12-month testing period starting on your date of hire if you were hired after the annual required testing period stated previously. This testing is required under the Affordable Care Act. If you work an average of 30 or more hours per week during the applicable testing period, you will be notified of your eligibility and offered participation in medical coverage no later than the first day of the month following 30 days after the end of the testing period.

**The Plan Administrator may act by resolution to provide for earlier participation for employees who become employees of a Participating Affiliate as a result of an acquisition (of assets or equity) or merger ("Transferred Employees"). However, if adopting an early participation date for Transferred Employees would result in an increase in the costs of funding or administering the Plan of more than 5% or $500,000, the Plan Administrator may only provide for such earlier participation to the extent required by the applicable acquisition or merger or related agreement.

CONTINUATION COVERAGE RIGHTS UNDER COBRA
VERY IMPORTANT NOTICE

Introduction

You are receiving this notice because you have recently become covered under the medical, dental, vision, life insurance (for required states), employee assistance program (EAP), and/or health care spending account benefits under the Knife River Corporation Health and Welfare Benefits Program (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. When you become eligible for COBRA, you may become eligible for other coverage options that costs less than COBRA continuation coverage.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's appropriate Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is Knife River Corporation Employee Benefits Committee. COBRA continuation coverage for the Plan is administered by the COBRA Administrator, PayFlex Systems USA, Inc. Contact information for the Plan Administrator and the COBRA Administrator is located at the end of this notice.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about the Marketplace below.

What is COBRA Continuation Coverage?

COBRA 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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse (as defined by the Plan), and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You will be notified at the time you are offered COBRA continuation coverage of the amount and the date payment is due.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

(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 lose coverage under the Plan because of the following qualifying events:

(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;
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

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

(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/her gross misconduct;
(4) The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) 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 Knife River Corporation 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 become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to Knife River Corporation; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all 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 Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Knife River Corporation Employee Benefits Committee, 1150 West Century Ave, Bismarck, North Dakota 58503.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. You may elect COBRA for your health care spending account benefit through the end of the plan year in which the qualifying event occurs.

A different maximum period of COBRA continuation coverage applies for medical, dental, vision, life insurance, health care spending account and EAP benefits. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, medical, dental, vision, and EAP COBRA continuation coverage lasts for up to a total of 36 months. Life insurance continuation will be addressed in your life insurance certificate.

The maximum period of COBRA continuation coverage for the health care spending account benefits is through the end of the plan year in which coverage is lost due to any COBRA qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, medical, dental, vision, and EAP COBRA continuation coverage generally lasts for up to a total of 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are two ways in which the 18-month period of COBRA continuation coverage can be extended with respect to medical, dental, vision, and EAP benefits:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of medical, dental, vision, and EAP COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must make sure that the Plan Administrator is notified in writing 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 COBRA continuation coverage. This notice should be sent to: Knife River Corporation Employee Benefits Committee, 1150 West Century Ave, Bismarck, North Dakota 58503.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of medical, dental, vision, and EAP COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under

Part A, Part B, or both), or 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 Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Knife River Corporation Employee Benefits Committee, 1150 West Century Ave, Bismarck, North Dakota 58503.**

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your appropriate summary plan description, you should contact the COBRA Administrator, whose contact information is stated below.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about health insurance options available through a Health Insurance Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. For your records, you should also keep a copy of any notices you send to the Plan Administrator.

Eligibility

Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage (including retroactively, if necessary) if you are determined to be ineligible for coverage.

Plan Contact Information
The Plan Administrator is:

Knife River Corporation
Employee Benefits Committee
1150 West Century Avenue
Bismarck, North Dakota 58503
(701) 530-1416

The COBRA Administrator is:

Inspira Financial Health, Inc.
Benefit Billing Department
PO Box 953374
St. Louis, MO 63195-3374
(800) 359-3921 (TTY:711)

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 1/31/2026).