PreferredOne®
INSURANCE COMPANY

6105 GOLDEN HILLS DRIVE
GOLDEN VALLEY, MINNESOTA 55416

PREFERREDHEALTH SILVER 26 INDIVIDUAL CONTRACT

This is *your contract* while *you* are covered. It explains *your* rights and benefits under this *contract*. This *contract* is a legal contract between *you* and *us*. All coverage under this *contract* begins at 12:01 AM Central Time.

This *contract* along with any amendments and *your* application constitutes the entire agreement under which payments are made. *We* will pay the benefits set forth in this *contract*. Benefit payment is governed by all the terms, conditions, and limitations of this *contract*. This *contract* may be amended at any time without *your* consent. Notice will be provided at least 30 calendar days in advance of any amendment taking effect. Any such amendment will not affect a claim starting before the amendment takes effect. This *contract* has been issued and delivered to *you* in Minnesota. Except as otherwise stated in this *contract*, this *contract* will be governed by federal law and the laws of Minnesota.

This *contract* was issued on the basis that the information on *your* application was correct and complete. If any of this information provided was not correct, write to *us* within ten calendar days of receipt of this *contract*. An error or omission on *your* application or in *your* enrollment process, as applicable, may cause *us* to ask *you* to pay an increased *premium.* If *you* misstate *your* age or make other unintentional errors, *PIC* will refund overpayments or collect the balance due based on *your* correct age. *PIC* can rescind *your* coverage for intentional misrepresentation, or fraud. After *your* coverage under this *contract* is validly in effect, its validity cannot be contested unless *you* (or anyone seeking coverage on *your* or *your dependent's* behalf, including a personal representative) performed an act, practice, or omission that constitutes fraud, or *you* or *your dependent* made an intentional misrepresentation of material fact (including a misleading omission of material fact). "Material facts" may include, for example, statements or omissions on the application or in the enrollment process, as applicable, made as part of *your* enrollment and claims for coverage or reimbursement that misrepresent an individual's continuing status as a *dependent*.

TIME LIMIT ON CERTAIN DEFENSES. After *your* coverage under this *contract* has been in effect for two years *PIC* cannot void, rescind or deny *your* claims because of a misstatement provided as part of *your* enrollment, unless such misstatement is a fraudulent misstatement.

NOTICE. This disclosure is required by Minnesota law. This *contract* is expected to return on average 80% of *your premium* dollar for health care. The lowest percentage permitted by federal and state law for this *contract* is 80%.

RIGHT TO CANCEL. ***You* may cancel this *contract* back to its *effective date* by delivering or mailing a written notice to PreferredOne Insurance Company (*PIC*) at 6105 Golden Hills Drive, Golden Valley, Minnesota 55416, and by returning this *contract* to *PIC* before midnight of the tenth day (or the 30th day if this is a replacement *contract*) after receipt of this *contract.* Then within ten calendar days after *PIC* receives notice of cancellation and the returned *contract, PIC* must return all *premiums*, (including any fees or charges, if applicable) *you* paid for this *contract.* Notice given by mail and return of this *contract* by mail are effective on being postmarked, properly addressed and postage prepaid. *PIC* has the right to cancel this *contract* back to the last paid through date, decline to issue, or not renew this *contract* if required *premiums* are not received when due, or if *PIC* ceases doing business in the individual health plan market.**

ACCEPTANCE OF THIS *CONTRACT*. *PIC*'s receipt of the full amount due for *your* first monthly premium will signify *your* acceptance of all terms, conditions, and obligations of this *contract*. Acceptance will be effective on the *effective date* of this *contract.*

READ *YOUR CONTRACT* CAREFULLY.

IN WITNESS WHEREOF, *our* President and Secretary hereby sign this *contract*.

David P. Crosby
President

Debra J. R. Shoemaker
Secretary

This *contract* may qualify as a qualified high deductible health plan within the meaning of Internal Revenue Code ("Code") section 223. This *contract* may be used in connection with a health savings account (within the meaning of Code section 223) established by a *member*. *PIC* will not be required to establish, maintain, or contribute to a health savings account on behalf of a *member*. If, however, this *contract* provides coverage for non-preventive benefits below the annual limit on *deductibles* set forth in Internal Revenue Code section 223, *you* may be ineligible to make or receive contributions to *your* health savings account ("HSA") under federal law. Please check with *your* tax advisor regarding *your* eligibility to establish or contribute to an HSA.

***PIC* Customer Service**	
Questions?	***Our* Customer Service staff is available to answer questions about *your* coverage Monday through Friday, 7 AM – 7 PM Central Time** **When contacting *us*, please have *your member* identification card available. If *your* questions involve a claim, *we* will need to know the date of service, type of service, the name of the *provider*, and the charges involved.**
Telephone Numbers:	**Monday through Friday 7 AM - 7 PM Central Time .....763.847.4477** **Toll free .....1.800.997.1750** **Fax .....763.847.4400** **Hearing impaired individuals 763.847.4013**
Website:	**www.preferredone.com**
Mailing Address:	**Notice of claims, proof of loss, review requests, pre-certification, prior authorization, and written inquiries may be mailed to:** **Customer Services Department** **PreferredOne Insurance Company** **PO Box 59212** **Minneapolis, MN 55459-0212**

PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
Email: customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ့် ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013).។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).

TABLE OF CONTENTS

		Page
I.	Important *Member* Information	1
II.	*Member* Rights and Responsibilities	1
III.	Disclosure of *Provider* Payments	2
IV.	*Member* Information for *Non-Participating Provider Benefits*	2
V.	General Provisions	2
	A. Introduction to *Your* Coverage	2
	B. Non-*Emergency Services* Received in a *Participating Provider* Facility from a *Non-Participating Provider*	2
	C. Referrals and Open Access	3
	D. Medical *Emergency*	3
	E. The Entire *Contract*	3
	F. Summary of Benefits and Coverage (SBC)	3
	G. *Your* Identification Card	3
	H. *Provider* Directory	3
	I. *Premium* Payment	4
	J. Grace Periods	4
	K. Reinstatement at Renewal	4
	L. Changes in Coverage	5
	M. Conflict with Existing Law	5
	N. Privacy	5
	O. Fraud or Intentional Misrepresentation and *Rescission*	5
	P. Authorizations and Right to Audit	5
	Q. Assignment	5
	R. Medical Equipment, Supplies and *Prescription Drugs*	6
	S. Medical Technology and Treatment Review	6
	T. Recommendations by Health Care *Providers*	6
	U. Legal Actions	6
	V. Limited Access to *Participating Providers*	6
	W. *Routine Patient Costs* Associated with *Clinical Trials*	6
	X. Medication Therapy Management Program	6
	Y. Good Faith Estimate	7
VI.	Eligibility, Enrollment, and *Effective Date*	8
VII.	Schedule of Payments	15
VIII.	Pre-certification Requirement and Prior Authorization Recommendation	17
IX.	Description of Benefits	20
	A. Ambulance Services	20
	B. Chiropractic Services	21
	C. Dental Services	22
	D. Durable Medical Equipment (“DME”) Services, Prosthetics, and Orthotics	23
	E. *Emergency Services*	25
	F. Home Health Services	26
	G. Hospice Care	28
	H. *Hospital* Services	29
	I. *Infertility* Services	33
	J. Office Visits	34
	K. Organ and Bone Marrow *Transplant Services*	38
	L. Physical Therapy, Occupational Therapy and Speech Therapy	40
	M. *Prescription Drug* Services	41
	N. Preventive Contraceptive Methods and Counseling for Women	47
	O. *Preventive Health Care Services*	49
	P. *Reconstructive* Surgery	53
	Q. *Skilled Nursing Facility* Care	54
	R. Specified *Non-Participating Provider* Services	55
	S. Vision Care – Pediatric	56
X.	Exclusion List	58
XI.	Ending *Your* Coverage	67
XII.	Portability of Coverage	67
XIII.	Subrogation and Reimbursement	68

XIV. Coordination of Benefits **69**
XV. How to Submit a Claim if *You* Receive a Bill for *Covered Services* from a *Provider* **72**
XVI. Initial Benefit Determinations of *Post-Service Claims* **73**
XVII. Complaints **74**
XVIII. Internal Appeals Process **74**
XIX. External Review Process **75**
XX. Definitions **76**
Notice Concerning Policyholder Rights in an Insolvency **85**
***Your* Rights Related to *Your* Mental Health and Substance Use Disorder Benefits** **86**

I. Important *Member* Information

Contract Year. *Your* first contract year begins on the *effective date* of *your* coverage and ends on December 31 of that *calendar year*. Subsequent contract years run on a *calendar year* basis, January 1 through December 31.

Covered Services. This *contract* defines what services are covered by *PIC* and describes procedures *you* must follow to obtain coverage.

Essential Health Benefits. This *contract* covers all *essential health benefits. Essential health benefits* are subject to some limitations or exclusions under this *contract*.

Exclusions. Certain services or medical supplies are not covered. *You* should read this *contract* for detailed explanation of all exclusions.

Providers. Enrolling in *PIC* does not guarantee services by a particular *provider* on the list of *providers*. When a *provider* is no longer participating with *PIC*, *you* must choose among remaining *PIC participating providers*. Contact *PIC* Customer Service for the most recent listing of *PIC providers*.

Wellness. *PIC* may offer and provide wellness and fitness incentives to *you* in connection with services received from *PIC* or designated third party vendors.

Notice Applicable to Nondiscrimination on the Basis of Sex or Gender Identity. *PIC* does not discriminate on the basis of sex or gender identity and does not limit *health care services* or impose additional cost sharing for *health care services* that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such *health care services* are ordinarily or exclusively available.

II. *Member* Rights and Responsibilities

As a *PIC member, you* have the following rights and responsibilities:

1. A right to receive information about *PIC*, its services, its *participating providers* and *your member* rights and responsibilities.
2. A right to be treated with respect and recognition of *your* dignity and right to privacy.
3. A right to available and accessible services, including *emergency services*, 24 hours a day, 7 days a week.
4. A right to be informed of *your* health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
5. A right to participate with *providers* in making decisions about *your* health care.
6. A right to a candid discussion of appropriate or *medically necessary* treatment options for *your* conditions, regardless of cost or benefit coverage.
7. A right to refuse treatment.
8. A right to privacy of medical, dental and financial records maintained by *PIC* and its *participating providers* in accordance with existing law.
9. A right to voice complaints and/or appeals about *PIC* policies and procedures or care provided by *participating providers*.
10. A right to file a complaint with *PIC* and the Department of Commerce and to initiate a legal proceeding when experiencing a problem with *PIC* or its *participating providers*. For information, contact the Minnesota Department of Commerce at 651.539.1600 or 1.800.657.3602 and request information.
11. A right to make recommendations regarding *PIC's member* rights and responsibilities policies.
12. A responsibility to supply information (to the extent possible) that *participating providers* need in order to provide care.
13. A responsibility to supply information (to the extent possible) that *PIC* requires for health plan processes such as enrollment, claims payment and benefit management, and providing access to care.
14. A responsibility to understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
15. A responsibility to follow plans and instructions for care that *you* have agreed on with *your providers*.
16. A responsibility to advise *PIC* of any discounts or financial arrangements between *you* and a *provider* or manufacturer for *health care services* that alter the charges *you* pay.

III. Disclosure of *Provider* Payments

PIC contracts with *participating providers* to provide *health care services* to *you*. *Participating providers* submit claims for *eligible charges* to *PIC* with their usual charge for the *health care services*. *Your* benefits are determined based on the service and the claims' *eligible charges* that are paid according to the applicable *fee schedule*. This may be based on various methodologies, depending on the *provider* type and contract (i.e. per service, per event, per day, by diagnostic related group or percent of charge). The *deductible* and *coinsurance* amounts are based on the *fee schedule* amount.

A *participating provider* may contractually agree to a *risk allowance and risk sharing.* The money withheld, paid, pre-paid, or put at risk in the *risk allowance and risk sharing* may or may not be paid to or returned by the *participating provider*, depending on various circumstances, such as quality or coordination of care, efficiency, cost effectiveness, comparative total cost of care, *member* satisfaction, and/or the financial situation of *PIC*. The method by which the *risk allowance* is paid or returned may differ by *provider* type/specialty and therefore may vary among *participating providers*. *You* are not responsible for payment of any *risk allowance and risk sharing*. Factors such as the quality, coordination, efficiency and cost effectiveness of care that *participating providers* deliver may also affect future contract terms between *PIC* and *participating providers.*

Post-service c*laims* submitted to *PIC* for *non-participating provider benefits* are paid on a *fee-for-service* basis. *PIC* determines *your* benefits based on the *PIC non-participating provider reimbursement value.*

PIC does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

PIC is required to comply with Minn. Stat. § 62Q.75, subd. 1, which requires prompt payment of clean claims within 30 calendar days of receipt of the clean claim unless a longer period is allowed by law.

IV. *Member* Information for *Non-Participating Provider Benefits*

Covered Services. *PIC* covers specified services from *non-participating providers* at varying levels of coverage. *Deductibles, coinsurance,* and maximum benefit restrictions may apply. This *contract* lists the services available and describes the procedures for receiving coverage through *non-participating providers.*

Pre-certification. The section entitled "Pre-certification Requirement and Prior Authorization Recommendation" in this *contract* explains pre-certification. A reduction in the level of benefits may apply if *you* do not obtain pre-certification.

V. General Provisions

A. Introduction to *Your* Coverage

This *contract* describes *your PIC* health care coverage. *PIC* may not cover all of *your* health care expenses. Read this *contract* carefully to determine which expenses are covered. *PIC* has discretionary authority to determine eligibility for benefits under this *contract* and to interpret and construe terms, conditions, limitations, and exclusions of this *contract*. Many provisions are interrelated; therefore, reading just one or two provisions may not give *you* a complete understanding of the coverage described under this *contract*. Italicized words used in this *contract* have special meanings and are defined at the back of this *contract*.

B. Non-*Emergency Services* Received in a *Participating Provider* Facility from a *Non-Participating Provider*

If a *participating provider* arranges and/or performs services for *you* at a *participating provider* facility, all related eligible non-facility charges from both *participating providers* and *non-participating providers* are covered at the *participating provider* level of benefits as shown in the "Description of Benefits."

If a *non-participating provider* arranges or performs services for *you* at a *participating provider* facility with *your* written authorization, all related eligible non-facility charges from any *non-participating providers* are covered at the *non-participating provider* level of benefits, if any, as described in the "Description of Benefits."

If *you* receive *unauthorized provider services* from a *provider* those services will be covered as required under Minnesota §62Q.556.

C. Referrals and Open Access

Referrals are not required. *Your provider* may suggest that *you* receive a *health care service* from a specific *provider* or receive a specific *health care service*. Even though *your provider* may recommend or provide written authorization for a referral for certain *health care services*, the provider where *you* receive the *health care services* may be a *non-participating provider* or the recommended *health care service* may be covered at a lesser level of benefits or be specifically excluded. When these *health care services* are referred or recommended, a written authorization from *your provider* does not override any specific network requirements, pre-certification or prior authorization requirements, or plan benefits, limitations or exclusions.

This *contract* provides "open access" coverage. "Open access" coverage means that *you* may elect to receive *your health care services* from any *participating provider* in a *provider* network. The *provider* network includes *specialists*. The *provider* directory or designated website will assist *you* in finding *participating providers*. *You* may schedule appointments with such *participating providers*, including OB/GYNs, without any referral. However, it is important that *you* verify that the *provider* still participates with the *provider* network before *you* actually receive any *health care services*. If *you* have questions about the status of *participating providers*, *you* may call the Customer Service number listed on *your* ID card for assistance.

D. Medical *Emergency*

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If the situation is a medical *emergency* and if traveling to a *participating provider* would delay *emergency* care and thus endanger *your* health, *you* should go to the nearest medical facility. However, call *PIC* or *your participating provider* within 48 hours or as soon as reasonably possible to discuss *your* medical condition and to coordinate any follow-up care. *You* may authorize someone else to act on *your* behalf.

E. The Entire *Contract*

This *contract*, combined with any amendments (and *your* completed application), and any other documents referenced in this *contract*, excluding the Summary of Benefits and Coverage, constitute the entire *contract* between *you* and *PIC*. No change in this *contract* will be valid until approved by the executive officer of *PIC* and unless such approval is endorsed hereon or attached hereto. No agent has the authority to change this *contract* or to waive any of its provisions. *PIC* has the right to rely upon the information provided as part of *your* enrollment.

F. Summary of Benefits and Coverage (SBC)

The SBC is an informational summary of *your* benefits and coverage under this *contract*, including coverage examples, that is prepared in a uniform style. If there is a conflict between this *contract* and the SBC, this *contract* governs and *PIC* will administer *your* coverage in accordance with this *contract*. *You* can obtain the SBC by contacting *PIC* Customer Service or accessing the designated website.

G. *Your* Identification Card

PIC issues an identification (ID) card containing coverage information. Please verify the information on the ID card and notify *PIC* Customer Service if there are errors. If any ID card information is incorrect, claims or bills for *your* health care may be delayed or temporarily denied. *You* will be asked to present *your* ID card whenever *you* receive services.

H. *Provider* Directory

You may find *participating providers* on the designated website. Coverage may vary according to *your provider* selection.

The list of *participating providers* frequently changes, and *PIC* does not guarantee that a listed *provider* is a *participating provider*. *You* may want to verify that a *provider you* choose is a *participating provider* by calling *PIC* Customer Service. *Provider* directories are available to *you* upon request.

I. *Premium* Payment

Your premium payments are due monthly and, other than the first month, must be paid within a certain number of days after the premium due date. That number of days is known as the grace period, described further below. *PIC* has the right to change the *premium* due date and *premium* rates like *yours* and will notify *you* in advance of any changes. *Your premium* is the same as other *subscribers* of like age and number of *dependents* who are covered under contracts like *yours*. *We* notify *you* of the new *premium* on the billing statement if *your premium* changes.

This *contract* will continue in force as long as *premium* payments are made before the due date or within the grace period described below. *PIC* has the right to terminate this *contract* due to non-payment of *premium*, rescind this *contract* due to fraud or intentional misrepresentation, or to cancel this *contract* as otherwise described in the Ending *Your* Coverage provision of this *contract*. This *contract* will not be renewed if *PIC* ceases doing individual market business in Minnesota or as specified herein. Payment of a claim does not preclude *PIC* from denying future claims or taking any legal action it determines appropriate, including *rescission* and seeking repayment of claims already paid.

***Premium* Payment from Third Parties:** *PIC* does not accept *premium* payments from third parties including but not limited to employers of *members*, *subscribers* or *dependents*, except when (a) acceptance of payment from a third party is specifically required by applicable federal or state law, (b) payment of the entire monthly premium is made from or on behalf of an individual coverage health reimbursement account (ICHRA) by the sponsoring employer, administrator or third party administrator of such ICHRA or (c) payment is made by an affiliate of *PIC*. *PIC* may deny acceptance of, or stop accepting, *premium* payments from third parties only as permitted by applicable federal or state law.

J. Grace Periods

After *your* first payment of *premium*, *we* allow a 31-calendar day grace period for *premium* payment. The grace period starts on the day after the due date for payment. *You* are covered during this grace period provided payment of *premium* is made by the end of the grace period. If *we* do not receive payment by the end of the grace period, this *contract* is cancelled retroactively to the last date for which coverage has been paid in full.

If *your* coverage is terminated for nonpayment, *you* may not be able to obtain new coverage until the next annual open enrollment period, unless *you* experience a qualifying event that provides *you* or *your dependents* a right to a limited open enrollment period under this *contract*. The section entitled "Eligibility, Enrollment and *Effective Date*" in this *contract* explains annual open enrollment and limited open enrollment periods.

K. Reinstatement at Renewal

If *your* renewal *premium* is not paid by the end of the grace period granted to *you* for payment of such *premium*, *PIC* will not accept subsequent submission of such *premium* unless it is accompanied by *your* written application request for reinstatement and such application request is approved by *PIC* as described below. This written application request for reinstatement must be on a form provided by *PIC* and accompanied by full and complete payment of all *premium* due. *PIC* will review *your* application request for reinstatement upon receipt.

We may agree in writing to reinstate *your* coverage after the grace period has expired once without a break in coverage.

PIC will notify *you* in writing if *PIC* agrees to reinstate *your* coverage. After this one time reinstatement, *you* must reapply for coverage during the next annual open enrollment period, unless *you* experience a qualifying event that provides *you* or *your dependents* a right to a limited open enrollment period.

If *PIC* does not agree to reinstate *your* coverage, *PIC* is not responsible for claims that are for *covered services* received after *your* coverage under *PIC* ends.

PIC has 45 days following receipt of *your* written application request for reinstatement that is submitted in accordance with the procedures of this section to approve or deny such application request. If *PIC* does not approve or deny *your* application request for reinstatement within 45 days after receipt of such application request, *your* coverage will be reinstated upon the 45th day following the date such written application request for reinstatement was received by *PIC*.

This provision for reinstatement at renewal is limited to renewal *premiums*.

L. Changes in Coverage

PIC may discontinue offering all health insurance in the individual market. If that happens, *PIC* will provide *you* with written notice that coverage is being discontinued, as required by law.

The coverage provided under this *contract* and the *premiums* due for that coverage may change each year. Such changes may include changes in order to meet federal regulatory requirements, or state regulatory requirements to the extent that such requirements are not preempted by federal regulatory requirements, or to ensure that this *contract* maintains the actuarial value for the designated metal levels as defined in the *Affordable Care Act.* Any change in coverage required by statute or regulation becomes effective according to statute or regulation.

PIC may also modify or non-renew this *contract* on a uniform basis among all individuals with the same coverage as long as such change is in compliance with applicable federal law, or state law to the extent that such law is not preempted by federal law. *PIC* may also non-renew this *contract* if the *subscriber* moves outside the Minnesota service area for this *contract.* This *contract* is guaranteed renewable at a premium rate that does not take into account *your* claims experience or *your* health status.

If coverage is modified, *PIC* will provide *you* written notice of the change, as required by law.

M. Conflict with Existing Law

If any provision of this *contract* conflicts with any applicable statute or regulation, only that specific provision is hereby amended to conform to the minimum requirements of such statute or regulation.

N. Privacy

PIC is subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule. In accordance with the HIPAA Privacy Rule, *PIC* maintains, uses, or discloses *your* Protected Health Information for purposes such as claims processing, utilization review, quality assessment, case management, and otherwise as necessary to administer *your PIC* health care coverage. *You* will receive a copy of *PIC's* Notice of Privacy Practices (which summarizes *PIC's* HIPAA Privacy Rule obligations, *your* HIPAA Privacy Rule rights, and how *PIC* may use or disclose health information protected by the HIPAA Privacy Rule) with *your* enrollment packet. *You* may also call *PIC* Customer Service to receive one.

O. Fraud or Intentional Misrepresentation and *Rescission*

If routine processing delays or clerical errors occur, those delays will not deprive *you* of coverage for which *you* are otherwise eligible, nor will they give *you* coverage under this *contract* for which *you* are not eligible under this *contract*. *You* will not be eligible for coverage beyond the scheduled termination of this *contract* because of a failure to record or communicate the termination except where required by law. *Your* coverage may not be rescinded unless *you* (or anyone seeking coverage on *your* behalf, including a personal representative) falsify, or intentionally misrepresent or omit, information on *your* enrollment application form, submit fraudulent, altered or duplicate billings for *your* or others' personal gain, allow another person not covered under this *contract* to use *your* coverage, or perform an act or practice that constitutes fraud or intentional misrepresentation (including an omission) of material fact under the terms of this *contract*. *PIC* will provide *you* with a minimum of 30 calendar days advance written notice of the pending *rescission*. Notwithstanding this, *your* coverage may be terminated, including being retroactively terminated, due to *your* failure to timely pay *your* required *premiums*.

P. Authorizations and Right to Audit

Determination of *your* coverage will be made at the time a claim is reviewed. In addition, *PIC* or its designee may require *you* to furnish proof of *your* eligibility status, including eligibility for limited open enrollment, and may, at reasonable times and upon reasonable notice, audit or have audited *your* records regarding eligibility, enrollment, termination, *premium* payments and the coverage provided under this *contract*. If *PIC* determines that, after reasonable requests, *you* have failed to provide adequate records or authorizations for the release of information, or sufficient proof, *PIC* may, in its sole discretion, deny claims, cancel or not renew *your* coverage or rescind or terminate *your* coverage to the extent permitted by law.

Q. Assignment

PIC will have the right to assign any and all of its rights and responsibilities under this *contract* to any affiliate of *PIC* or to any other appropriate organization or entity.

R. Medical Equipment, Supplies and *Prescription Drugs*

Your coverage under this *contract* does not guarantee that coverage of medical equipment, supplies or *prescription drugs* will continue to be covered, even if the equipment, supply or drug was covered in a previous *calendar year*.

S. Medical Technology and Treatment Review

Depending on the focus of the technology or treatment, one of two committees (Integrated Health Quality Management Subcommittee or the Pharmacy and Therapeutics Quality Management Subcommittee) determines whether new and existing medical treatments and technology should be covered benefits. These committees are made up of PreferredOne staff and independent community *physicians* who represent a variety of medical specialties. Their goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. These committees carefully examine the scientific evidence and outcomes for each treatment/technology being considered. The Quality Management Committee that is made up of independent community *physicians*, a consumer representative, and PreferredOne staff oversees the decisions of the subcommittees.

T. Recommendations by Health Care *Providers*

In some cases, *your provider* may recommend or provide written authorization for services that are specifically excluded by this *contract*. When these services are referred or recommended, a written authorization from *your provider* does not override any specific *contract* exclusions.

U. Legal Actions

No legal action may be brought until at least 60 calendar days after written proof of loss is provided or after the expiration of three years after the date that written proof of loss was provided.

V. Limited Access to *Participating Providers*

In the event that *PIC* determines *you* are receiving *health care services* or *prescription drugs* in a quantity or manner that might be harmful to *your* health, *PIC* will notify *you* that *your* access to *participating providers* is limited. *You* will have 30 calendar days in which to select one participating *physician, hospital* and pharmacy to coordinate *your* health care. If *you* do not select those *participating providers* within 30 calendar days, *PIC* will select them for *you.*

Failure to receive health care services and supplies through *your* selected *participating providers* will result in denial of coverage. If *your* condition requires care or treatment from other *providers*, *you* must obtain a written referral from *your* selected participating *physician*.

W. *Routine Patient Costs* Associated with *Clinical Trials*

PIC covers *routine patient costs* associated with a *clinical trial* and may not: 1) deny *your* participation in a *clinical trial*; 2) deny (or limit or impose additional conditions on) the coverage of *routine patient costs* for items and services furnished to *you* in connection with participation in the *clinical trial*; or 3) discriminate against *you* on the basis of *your* participation in a *clinical trial.*

If one or more *participating providers* are participating in a *clinical trial*, *PIC* will cover *routine patient costs* only if *you* participate in the *clinical trial* through a *participating provider* if the *provider* will accept *you* as a participant in the *clinical trial.* This requirement is waived if the approved *clinical trial* is conducted outside the state in which *you* reside. *PIC* will not cover *routine patient costs* if *you* are participating in a *clinical trial* with a *non-participating provider* and *you* do not have coverage for *non-participating provider benefits*.

X. Medication Therapy Management Program

If *you* meet *our* criteria for coverage, *you* might qualify for the Medication Therapy Management program which covers certain consultations with a designated pharmacist. To obtain more information, contact *PIC* Customer Service.

Y. Good Faith Estimate

At *your* request, if *you* are intending to receive specific *health care services, PIC* will provide *you* with a good faith estimate of the allowable amount that *PIC* has contracted with a specified *participating provider* under *PIC*'s *fee schedule* for such specified *health care service*, the portion due from *you* (including *deductible, coinsurance and copayments)* and *your* out-of-pocket costs. An estimate provided to *you* under this paragraph is not a legally binding estimate of the *fee schedule* amount or *your* out-of-pocket cost.

PIC will provide *you* such good faith estimate within ten business days from the day a complete request is received by *PIC* which includes all the patient and *health care service* information that *PIC* requires to provide a good faith estimate. For purposes of this section, a good faith estimate is not a guarantee of final costs for services received from a *participating provider*; or a final determination of eligibility for coverage of benefits or *provider* network participation under this *contract*.

VI. Eligibility, Enrollment, and *Effective Date*

Eligible Individuals. An individual is eligible for coverage as a *subscriber* under this *contract* if, at the time of application, the *subscriber* is a resident in the service area for which this *contract* is issued, and has been determined by *PIC* to be an *eligible individual*.

Note: Coverage will be rescinded or terminated in the event of fraud, intentional misrepresentation of material fact (including a misleading omission of material fact) or failure to pay, when due, any required *premium*.

Eligible *Dependents*. A *subscriber* is permitted to enroll only eligible *dependents*. Eligible *dependents* of the *subscriber* include those individuals whom *PIC* has determined to be *eligible individuals* and who meet the requirements of any of the following:

1. Lawful spouse whose marriage to the *subscriber* is valid under Minnesota law.
2. Children, through end of the month in which the child reaches age 26, including:
    a. Natural children of a covered *subscriber* from birth.
    b. Legally adopted children or children placed with the *subscriber* for legal adoption (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).
    c. Children for whom the *subscriber* or the *subscriber's* covered lawful spouse has been appointed legal guardian by a court of law, up to the age stated in the court appointment if less than age 26.
    d. *Stepchildren* of the *subscriber*.
    e. Grandchildren of the *subscriber* or the *subscriber's* covered lawful spouse who have resided in the covered grandparent's home continuously since the date of the initial discharge from the *hospital* due to birth and are dependent on the covered grandparent for their financial support.
3. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to *PIC* within 31 calendar days after the dependent child reaches age 26. *PIC* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, *PIC* may request proof again at any time during the two-year period following the child's attainment of the limiting age but not more frequently than annually after such two-year period. A dependent child may be eligible for coverage if coverage has not otherwise terminated by *PIC* and if the dependent child meets all of the following criteria:
    a. Became disabled before age 26;
    b. Was a *dependent* enrolled with *PIC* under this *contract* prior to reaching age 26;
    c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental disability, mental illness, or mental health disorder; and
    d. Is dependent on the *subscriber* for a majority of support and maintenance.

    The disabled dependent child shall be eligible for coverage as long as the dependent child is and continues to be disabled and dependent on the *subscriber*, unless coverage otherwise terminates under this *contract.*

Note: Coverage will be rescinded or terminated in the event of fraud, intentional misrepresentation of material fact (including a misleading omission of material fact) or failure to pay, when due, any required *premium*.

Initial Enrollment and Subsequent Enrollment. The *subscriber* must make written application to enroll, including any eligible *dependents* that the *subscriber* wishes to enroll, during an open enrollment period which occurs from November 1 through December 15 of each year. The *subscriber* may add eligible *dependents* to this *contract* at subsequent annual open enrollment periods. They may also be enrolled in connection with a limited open enrollment period as described in the "Limited Open Enrollment," Section below. For further information regarding open enrollment, please contact *PIC* Customer Service. If *you* have subscriber only coverage and elect coverage for *your* eligible *dependents* which becomes effective, then *you* and *your dependents* become subject to the terms and conditions of family coverage.

Newborn Child Enrollment Under Minnesota Law. Newborn infants, including the *subscriber's* newborn grandchildren, who were born while the *subscriber* is covered under this *contract* and enrolled for coverage of two or more *eligible individuals* and who are otherwise eligible for coverage, will be covered immediately from the date of birth, regardless of when notice is received by *PIC.* If *you* submit an application more than 60 calendar days after the date of birth, the newborn will still be covered back to the date of birth; however, there may be claim processing delays until the application is received and any required *premiums* are paid in full. *PIC* must receive required payments, if any, from the date of birth before benefits

will be paid. The *subscriber* must be covered under this *contract* and enrolled for coverage of two or more *eligible individuals* in order for the newborn infant to also obtain coverage under this *contract*.

Newly Adopted Child Enrollment Under Minnesota Law. Children newly adopted or placed for adoption, who were adopted or placed for adoption while the *subscriber* is covered under this *contract*, and who are otherwise eligible for coverage, will be covered immediately from the date of adoption or placement for adoption, regardless of when notice is received by *PIC*. If *you* submit an application more than 60 calendar days after the date of adoption, or placement for adoption, the adopted child will still be covered back to the date of adoption, or placement for adoption; however, there may be claim processing delays until the application is received and any required *premiums* are paid in full. *PIC* must receive required payments, if any, from the date of adoption or placement for adoption before benefits will be paid. The *subscriber* must be covered under this *contract* in order for the adopted child to also obtain coverage under this *contract*.

***Effective Date* for Initial Enrollment.** The date on which coverage is effective for the *subscriber* and all enrolled *dependents* who are listed on the application depends on the date *you* are approved for coverage by *PIC* and *PIC*'s receipt of the full amount due for *your* first monthly *premium* payment. If the conditions are met on or before December 15 in any calendar year, *your* coverage will be effective January 1 of the following calendar year.

Limited Open Enrollment. If *your* circumstances change, *you*, *your* spouse, and *your dependents* may have a limited open enrollment right to enroll in this *contract* or another *health plan* or in a *qualified health plan*, as applicable. The events that may permit such limited open enrollment in this *contract* are generally described in the chart below; **however, they are subject to change as permitted or required by law, regulatory guidance or applicable market practices**. The chart contains the events that apply when *you* purchase coverage directly from *PIC* under this *contract*. If one of the listed events applies to *you*, *you* must elect coverage in a timely manner as required by law, and must submit *your* completed application to *PIC* to obtain coverage under this *contract*.

The timeframe for electing coverage varies with the type of event.

- For events 3, 4, 5, 9 and 10 in the chart below, coverage must be elected no later than 60 calendar days after the date the event occurs. For events involving a child support order or other court orders, the date the event occurs is the date the order is issued.
- For events 1 and 2 in the chart below, coverage must be elected during the period that begins 60 days before and ends 60 days after the date the event occurs.
- For events 6 and 7 in the chart below, the coverage election periods vary with the circumstances, but generally cannot exceed 60 days.
- For event 11 in the chart below, coverage must be elected no later than 60 calendar days from the date of such event.
- Special rules apply to events 12 and 13. Contact *PIC* Customer Service if you have questions about these special rules.

In addition to electing timely, for events 1, 2, 3, 4, 5, 7 and 8, an *eligible individual* must demonstrate either enrollment in *minimum essential coverage* for at least 1 day during the 60 day period prior to the date of the event or that the *eligible individual* lived in a foreign country or U.S. territory for 1 or more days during the 60 day period prior to the date of the event or lived in a service area where no *qualified health plans* were available through MNsure (i) for 1 or more days during the 60 day period prior to the date of the event or (ii) during their most recent preceding enrollment period (which includes initial, annual or a limited open enrollment period). In addition to electing timely, for event 11, an *eligible individual* must demonstrate that they are currently enrolled in *minimum essential coverage* at the time they seek to enroll in coverage that is separate from the perpetrator's coverage. For further information regarding these limited open enrollment rules, please contact *PIC* Customer Service.

Note: If you are an *eligible individual* or a *qualified individual*, as applicable, or a spouse or an eligible dependent child of an *eligible individual* or a *qualified individual*, as applicable, but are not enrolled for coverage under this *contract*, you may also enroll for coverage under this *contract*, as provided by the *Affordable Care Act*, as a result of qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. For further information regarding these limited open enrollment rules, please contact *PIC* Customer Service.

***Effective Date* of Coverage Pursuant to Limited Open Enrollment.** The *effective date* of coverage for the *subscriber* and/or any eligible *dependents* depends on the date on which *PIC* timely receives *your* coverage selection and approves it, and *PIC* receives the full amount of the first monthly *premium* payment.

- If the event is the birth, adoption, placement for adoption or child support or other court order in relation to an eligible dependent child as set forth in events 3 or 4 in the chart below, coverage is effective on the date of the birth, adoption, placement for adoption or effective date of the court order; unless the *subscriber* elects that the coverage be effective on the first day of the month following plan selection or unless *subscriber* elects the regular coverage *effective dates*; provided that all conditions described in this section are met. For regular coverage *effective dates*, if plan selection is received on or after the first day of the month, but on or before the fifteenth day of the month, *your* regular coverage *effective date* will be the first day of the following month and if plan selection is received after the sixteenth day of the month, but on or before the last day of the month, *your* regular coverage *effective date* will be the first day of the second following month.
- If the event is marriage as set forth in events 3 or 4 in the chart below, coverage is effective on the first day of the month following the date the *subscriber* timely elects coverage, provided that all conditions described in this section are met.
- For event 5 in the chart below, coverage is effective on the first day of the month following the date the *subscriber* timely elects coverage, provided that all conditions described in this section are met.
- If the event is the loss of *minimum essential coverage* or the loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan* or an employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act* and as set forth in events 1 or 2 in the chart below, coverage is effective on the first day of the month following the date of the loss of coverage, provided that the *subscriber* timely elects coverage on or before the date of such loss and provided that all conditions described in this section are met. If *subscriber* timely elects coverage after the date of such loss of coverage, coverage is effective on the first day of the month following plan selection. For a loss of coverage due to such non-renewal or expiration of coverage, the date of the loss of coverage is the last day of the non-calendar plan year that immediately precedes the renewal date or the last day of the non-calendar plan year in which coverage expired, respectively. Special rules apply if coverage is elected after the loss of coverage occurs.
- If the event is a permanent move as set forth in event 8 in the chart below, if all conditions described in this section are met on or after the first day of the month, but on or before the fifteenth day of the month, *your* coverage under the events listed below will be effective on the first day of the following month. If the conditions are met on or after the sixteenth day of the month, but on or before the last day of the month, *your* coverage will be effective on the first day of the second following month. Special rules apply if coverage is elected before the permanent move occurs.
- For events 9,10 and 11 in the chart below, if all conditions described in this section are met on or after the first day of the month, but on or before the fifteenth day of the month, *your* coverage under the events listed below will be effective on the first day of the following month. If the conditions are met on or after the sixteenth day of the month, but on or before the last day of the month, *your* coverage will be effective on the first day of the second following month.
- The coverage effective dates for events 6, 7, 12 and 13 vary with the circumstances and special rules apply.

For further information regarding these limited open enrollment election period rules, please contact *PIC* Customer Service.

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
1. An *eligible individual* experiences: ▪ An involuntary loss of *minimum essential coverage*[1], or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan* or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act*. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The *subscriber* ▪ Individuals who are the *subscriber's* spouse and/or eligible dependent children.	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan.*
2. An *eligible individual's* spouse and/or eligible dependent children experience: ▪ An involuntary loss of *minimum essential coverage*[1], or ▪ A loss of coverage due to non-renewal (including voluntary non-renewal) or expiration of coverage under a non-calendar year group or individual *health plan* or a non-calendar year employer-sponsored plan that provides minimum value in accordance with the *Affordable Care Act*. ▪ A loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
3. A *subscriber* newly gains or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order.	▪ The *subscriber* ▪ Individuals who are the *subscriber's* spouse and/or eligible dependent children of the *subscriber* or of the new spouse	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan* or a group health plan
4. An *eligible individual* newly gains or becomes a spouse or newly gains an eligible dependent child through marriage, birth, adoption, placement for adoption, child support order or other court order.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual* or of the new spouse	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan* or a group health plan
5. An *eligible individual* who is enrolled in a *qualified health plan* loses a *dependent* or is no longer considered a *dependent* through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the *eligible individual* who is enrolled in a *qualified health plan* or a *dependent* dies.	▪ The *eligible individual.* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*.	▪ Enroll in this *contract.* ▪ Change *your* enrollment to another *health plan* or a group health plan.
6. MNsure determined that an *eligible individual* whose enrollment or non-enrollment in a *qualified health plan* is the result of an error, misrepresentation, misconduct or inaction by MNsure, the U.S. Department of Health and Human Services, or a non-exchange entity that provided MNsure enrollment assistance or conducted MNsure enrollment activities with you, as determined by MNsure in accordance with guidelines and standards established by MNsure. **Note:** For purposes of this event, a non-exchange entity is defined as an agent, broker, certified application counselor, navigator, issuer application assister, *qualified health plan* participating in MNsure and non-Navigator assistance personnel that assist consumers in enrolling in a *qualified health plan* through MNsure.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
7. An *eligible individual* who is enrolled in a *qualified health plan* adequately demonstrates to the applicable state authority within the meaning of federal law in accordance with guidelines and standards established by such authority, that such *qualified health plan* substantially violated a material provision of its contract in relation to such *qualified individual.*	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
8. An *eligible individual* makes a permanent move into a Minnesota service area or into a new service area in Minnesota, which causes such individual to gain access to a new *qualified health plan.*	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
9. MNsure determines that an *eligible individual* who is enrolled in a *qualified health plan* is newly ineligible for the advance payment of premium tax credits as defined by the *Affordable Care Act*.	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
10. MNsure determines that an *eligible individual*'s dependent enrolled in the same *qualified health plan* as the *eligible individual*: ▪ Is newly ineligible for the advance payment of premium tax credits as defined by the *Affordable Care Act.*	▪ The *eligible individual* ▪ Individuals who are the spouse and/or eligible dependent children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
11. An *eligible individual* who is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2 who is enrolled in *minimum essential coverage* and seeks to enroll in coverage separate from the perpetrator of such abuse or abandonment.	▪ The *eligible individual* who is the victim of such abuse or abandonment ▪ Individuals who are eligible *dependents* of the victim	▪ Enroll in this *contract* ▪ Any eligible *dependents* must enroll in this contract at the same time and on the same application as the victim ▪ End *your* coverage under this *contract* in order to enroll in other coverage that is separate from the perpetrator of such abuse or abandonment

LIMITED OPEN ENROLLMENT RULES THAT APPLY UNDER THIS *CONTRACT*		
These Limited Open Enrollment Right Events	**Apply to these Individuals**	**And Permit these Enrollment Changes**
12. An *eligible individual* or dependent who applies for MNsure coverage during open enrollment or due to a qualifying event, is determined potentially eligible for Medicaid or CHIP, but is determined ineligible after open enrollment ends or more than 60 days after the qualifying event	▪ The *eligible individual* ▪ Other *eligible individual*s who are the spouse and/or *dependent* children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*
13. An *eligible individual* or dependent who applies for state Medicaid or CHIP during open enrollment, but is determined ineligible after open enrollment ended	▪ The *eligible individual* ▪ Other *eligible individual*s who are the spouse and/or *dependent* children of the *eligible individual*	▪ Enroll in this *contract* ▪ Change *your* enrollment to another *health plan*

[1]For purposes of this *contract*, an involuntary loss of *minimum essential coverage* includes, but is not limited to, the following examples:

- Termination of health coverage, that is not COBRA or state continuation coverage, due to a loss of eligibility for such coverage (including as a result of legal separation or divorce from primary insured's subscriber, death of primary insured's subscriber, termination of employment or reduction in hours by the primary insured subscriber under an individual or group plan, cessation of dependent status (including but not limited to attaining age 26), and a loss of coverage provided through an HMO in the group or individual market or other arrangement due to the individual no longer residing or working in the service area designated by the HMO or other arrangement);
- Termination of all employer contributions toward the cost of such health coverage (excluding COBRA);
- Expiration of COBRA and any state continuation health coverage due to exhaustion of such coverage;
- Loss of medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act;
- Loss of pregnancy-related coverage under subsections (i)(IV) and (ii)(IX) of section 1902(a)(10)(A) of the Social Security Act; and
- An employer-sponsored health plan discontinues offering any health benefits to similarly situated individuals.

Loss of *minimum essential coverage* does not include, and is not limited to, the following examples:

- Voluntary loss of *minimum essential coverage*;
- Loss of non-*minimum essential coverage* unless an exception applies;
- Loss of *minimum essential coverage* due to a failure to pay *premiums* on a timely basis including COBRA *premiums* while on COBRA continuation coverage; and
- Loss of coverage due to a *rescission* of coverage (as permitted under the *Affordable Care Act*) by *PIC*, another carrier, a regulatory or government agency or an employer due to fraud or an intentional misrepresentation of material fact.

VII. Schedule of Payments

***You* are required to pay any *copayments, deductibles* and *coinsurance* amount. Benefits are covered in this *contract* according to what *PIC* pays for *covered services* it determines are *medically necessary. Medically necessary* is defined in the Definitions section of this *contract. Your coinsurance* amount is the *eligible charge* for a *covered service* less the percentage covered by *PIC*. *PIC* payment begins after *you* have satisfied any applicable *copayments, deductibles* and *coinsurance*.**

Discounts negotiated by or on behalf of *PIC* with *providers* may affect *your coinsurance* amount. *PIC* may pay higher benefits if *you* choose *participating providers*. In addition to any *copayments, coinsurance* and *deductible, you* also pay all charges that exceed the *PIC non-participating provider reimbursement value* when *you* use a *non-participating provider* and receive *non-participating provider benefits*.

Note: *Your* coverage is either "*subscriber* only" or "family." Therefore, only one of the following sections "*Subscriber* only" or "Family" applies to *you*. If *you* have questions about which section applies to *you*, contact *PIC*.

If *you* have *subscriber* only coverage, on the date that the coverage for *your* eligible *dependent(s)* becomes effective, *you* and *your* new *dependent(s)* become subject to the terms and conditions of family coverage.

Subscriber only

***Deductibles*:** The *subscriber* must first satisfy the *deductibles* by *incurring* charges equal to that amount for eligible services in a *calendar year* before *PIC* will pay benefits. *PIC* will not pay benefits for the *eligible charges* applied toward the *deductibles*. Expenses *you* pay for pre-certification penalties, *copayments, coinsurance* and any amount in excess of the *PIC non-participating provider reimbursement value* will not apply towards satisfaction of the *deductibles*. *You* will not be required to satisfy the *deductibles* before *PIC* will pay benefits for *preventive health care services* received from a *participating provider*.

***Out-of-Pocket Limits*:** After the *subscriber* has met the *out-of-pocket limit* per *calendar year* for *copayments, coinsurance* and *deductibles*, *PIC* covers 100% of charges *incurred* for all other *eligible charges*. It is the *subscriber's* responsibility to pay any amounts greater than the *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses *you* pay for pre-certification penalties and any amount in excess of the *PIC non-participating provider reimbursement value* will not apply towards satisfaction of the *out-of-pocket limit*.

***Subscriber* only**	***Participating Provider Network***	***Non-Participating Providers***
Deductibles	The *deductibles* for services received from *participating providers* and *non-participating providers* are not combined.	
	\$3,000 per *calendar year*.	\$15,000 per *calendar year*.
Out-of-Pocket Limits	The *out-of-pocket limits* for services received from *participating providers* and *non-participating providers* are not combined.	
	\$6,900 per *calendar year*.	No limit.

Family (*Subscriber* and Enrolled *Dependents*)

Family *Deductibles*: The family must first satisfy the family *deductibles* by *incurring* charges equal to that amount for eligible services in a *calendar year* before *PIC* will pay benefits in a *calendar year*. *PIC* will not pay benefits for the *eligible charges* applied toward the family *deductibles*. Expenses the family pays for pre-certification penalties, *copayments*, *coinsurance* and any amount in excess of the *PIC non-participating provider reimbursement value* will not apply towards satisfaction of the *deductibles*. *Members* of the family will not be required to satisfy the family *deductibles* before *PIC* will pay benefits for *preventive health care services* received from a *participating provider*.

Family *Out-of-Pocket Limits*: After the family has met the family *out-of-pocket limit* per *calendar year* for *copayments*, *coinsurance* and family *deductibles*, *PIC* covers 100% of charges *incurred* for all other *eligible charges*. The family must pay any amounts greater than the family *out-of-pocket limit* if any benefit or visit maximums are exceeded. Expenses the family pays for pre-certification penalties and any amount in excess of the *PIC non-participating provider reimbursement value* will not apply towards satisfaction of the *out-of-pocket limit*.

Family (*Subscriber* and *Dependents*)	***Participating Provider Network***	***Non-Participating Providers***
Family *Deductibles*	The *deductibles* for services received from *participating providers* and *non-participating providers* are not combined.	
	\$6,000 per family (\$3,000 per *member*) per *calendar year*.	\$25,000 per family per *calendar year*. No *member deductible* within the family *deductible*.
Family *Out-of-Pocket Limits*	The *out-of-pocket limits* for services received from *participating providers* and *non-participating providers* are not combined.	
	\$13,800 per family (\$6,900 per *member*) per *calendar year*.	No limit.

Cost Sharing. The amount of the flat fee *copayments* is calculated on *provider* allowed charges. The *provider's* allowed charge is the full amount that the *provider* bills less any discount negotiated by or on behalf of *PIC* with the *provider*. The *coinsurance* percentage is calculated on the least of the *provider's* allowed charge, the *fee schedule* that *PIC* has negotiated with the *participating provider*, or the *PIC non-participating provider reimbursement value.* The *deductible* is first subtracted from the allowed charge, *fee schedule*, or the *PIC non-participating provider reimbursement value*, whichever is applicable, then the *coinsurance* is applied to the remainder.

VIII. Pre-certification Requirement and Prior Authorization Recommendation

***PIC's* approval of a pre-certification or a prior authorization request does not guarantee payment for services. Whether or not *PIC* grants precertification or prior authorization, payment for services will depend on whether, at the time the services are performed, *you* are a *member* who is *eligible* for and enrolled under this *contract*, the services are *medically necessary*, are *covered services*, *you have* provided the appropriate information for those services, and *you* have met all other terms of the *contract*. Please read the entire *contract* to determine which other provisions might also affect benefits.**

If *your* attending *provider* requests pre-certification or prior authorization on *your* behalf, the attending *provider* will be treated as *your* authorized representative by *PIC* for purposes of such request and the submission of *your* claim and associated appeals unless *you* specifically direct otherwise to *PIC* within ten business days from *PIC's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

Provision	*Participating Provider Benefit*	*Non-Participating Provider Benefit*
Pre-certification Penalty	None.	*PIC* will reduce the amount of *eligible charges* by the lesser of $500 or 20% per *confinement* or per service listed below.

Pre-certification Requirement. Pre-certification is a review process that *PIC* performs before *you* obtain or receive certain medical services. During the review process, *PIC* determines whether or not the proposed services are *medically necessary*, and identifies situations where case management would be beneficial or medical management is required. The pre-certification process is required for the services listed below:

1. All non-emergency or elective inpatient admissions including, but not limited to, *hospitals*, rehabilitation facilities, behavioral health treatment facilities, etc.;
2. *Skilled nursing facility* care*;*
3. *Transplant services*; and
4. Non-*emergency* ambulance and ambulance transfers.

When a *participating provider* renders services, the *provider* will notify *PIC* for *you* and must follow the procedures set forth below. It is *your* responsibility to ensure that *PIC* has been notified by following the procedures set forth below when *non-participating providers* are used. *You* must contact *PIC* Customer Service by telephone, facsimile, electronic mail or voice mail prior to services being performed and without unreasonable delay. Failure to obtain pre-certification might result in a reduction of *non-participating provider benefits*. *Non-participating provider benefits* are not available for the services listed in items 2 and 3 above.

If *you* have questions about pre-certification and when *you* are required to obtain it, please contact *PIC* Customer Service.

Prior Authorization Recommendation. *PIC* recommends that *you* or *your provider* request prior authorization for certain services to determine whether they are *medically necessary*. When a *participating provider* renders services, the *provider* will obtain authorization in advance from *PIC* for *you* by following the procedures explained in this section of this *contract*. It is *your* responsibility to obtain prior authorization from *PIC*, and follow the procedures in this section of this *contract* when *you* receive services from *non-participating providers*. *Non-participating provider benefits* are not available for the services listed in items 2, 4 and 7 below. If *you* have questions about prior authorization, please contact *PIC* Customer Service. Pre-certification penalties do not apply. *You* and *your provider* should follow the same procedures for prior authorization as *you* follow for pre-certification with respect to obtaining services and submitting an appeal. The prior authorization process is recommended for a variety of services including but not limited to those listed below, and others that are listed in *PIC's* "Prior Authorization List" which *you* can access via the "Medical Policy" link on *your member* home page at www.preferredone.com:

1. Drugs or procedures that could be construed to be *cosmetic*;
2. Home health care or hospice;
3. Outpatient surgeries;
4. Physical therapy, occupational therapy, speech therapy and other outpatient therapies;

5. Pain therapy;
6. *Reconstructive* surgery; and
7. Durable medical equipment (DME) or prosthesis that might exceed $5,000.

You can access the current list by logging in to *your member* home page at www.preferredone.com.

PIC also recommends that *you* or *your provider* request prior authorization for certain *prescription drugs* before *you* fill *your* prescription at a pharmacy. These *prescription drugs* include, but are not limited to:

1. *Prescription drugs* that are over:
    a. $200 if a *compounded drug*;
    b. $1,500 if a retail prescription; or
    c. $2,500 if a mail order prescription.
2. *Specialty drugs.*

Pre-certification Procedures. When a *participating provider* renders services, the *participating provider* will notify *PIC* for *you* and must follow the procedures set forth below. It is *your* responsibility to ensure that *PIC* has been notified when *non-participating providers* are used. *You* or the *provider* must contact *PIC* Customer Service by telephone, facsimile, electronic mail, or voice mail prior to services being performed and without unreasonable delay. Failure to obtain pre-certification might result in a reduction of benefits. For *non-participating providers, you* need to follow the procedures set forth below:

1. *You* must contact *PIC* Customer Service by telephone, facsimile, electronic mail, or voice mail prior to services being performed and no less than 15 calendar days prior to the date services are scheduled. An expedited review is available if *your attending health care professional* believes it is warranted.
2. *You* and the *provider* will be notified of *PIC's* initial determination within ten business days following a request, but in no event later than the date on which the services are scheduled to be rendered, provided that *PIC* has all necessary information it needs to make an initial determination. If *PIC* has all information it needs to make an initial determination, but determines that an extension is necessary due to matters beyond its control, or the control of any associated group health plan, because it is subject to the requirements of the claims procedures under the US Department of Labor rules at 29 CFR §2560.503-1 *et seq.* in accordance with the *Affordable Care Act*, then *PIC* may extend the time period for its initial determination by sending written notice to *you* before the end of the initial determination period, which describes the circumstances that require the extension. *PIC* will notify *you* and the *provider* of its initial determination within ten business days after the end of the initial determination period. The initial determination will be communicated to the *provider* by telephone.
3. If *PIC* does not have all necessary information it needs to make an initial determination, then *PIC* may extend the time period for making the initial determination by sending written notice to *you*, before the end of the initial determination period, which describes the missing information and provides a grace period to *you* for providing the necessary information of at least 45 calendar days from the date *you* receive the notice. *PIC* will notify *you* and the *provider* of its initial determination within ten business days after the earlier of a) the date on which *PIC* receives the requested information and b) the end of the specified grace period, if *PIC* does not receive the requested information. The initial determination will be communicated to the *provider* by telephone.
4. If the initial determination is that the service will not be covered *your attending health care professional*, *hospital* (if applicable) and attending *provider* will be promptly notified by telephone within one business day after the decision has been made.
5. Written notification will then be provided to *you, your attending health care professional, hospital* (if applicable) and attending *provider* explaining the principal reason or reasons for the determination. The notification will also include the process to appeal the decision.
6. If *you* or the *provider* has not submitted the request for review in accordance with these procedures, *PIC* will notify *you* within five calendar days.

Note: If *your* request is denied, *you* may appeal that decision. Refer to the section entitled "Internal Appeals Process" for details on how to appeal.

Should Minnesota and/or the Minneapolis/St. Paul metropolitan area be declared subject to a pandemic alert or in the event of a cyber attack, *PIC* may suspend pre-certification requirements, prior authorization requirements, and other services as may be determined by *PIC.*

How to Obtain an Expedited Review

Expedited Review. An expedited initial determination will be used if *your attending health care professional* believes it is warranted. Acute care services, which can warrant expedited review, are medical care or treatment with respect to which the application of the time periods for making non-expedited review determinations could seriously jeopardize *your* life or health or *your* ability to regain maximum function, or that in the opinion of *your attending health care professional* would subject *you* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *pre-service claim.*

An expedited initial determination will be provided to *you, your attending health care professional, hospital* (if applicable) and attending *provider* as quickly as *your* medical condition requires, but no later than 72 hours following the initial request. If *PIC* does not have all information it needs to make a determination, *you* will be notified within 24 hours. *You* will then have at least 48 hours to provide the requested information. *You, your attending health care professional, hospital* (if applicable) and attending *provider* will be notified of the determination within 48 hours after the earlier of *PIC's* receipt of the requested information or the end of the time period specified for *you* to provide the requested information. If the initial determination would deny coverage, *you* or *your attending health care professional* will have the right to submit an expedited appeal

Note: If *your* request is denied, *you* may appeal that decision. Refer to the section entitled "Internal Appeals Process" for details on how to appeal.

Case Management

In cases where *your* condition is expected to be or is of a serious nature, *PIC* may arrange for review and/or case management services from a professional who understands both medical procedures and *PIC's* health care coverage.

Under certain conditions, *PIC* will consider other care, services, supplies, reimbursement of expenses or payments for care of *your* serious *sickness* or *injury* that would not normally be covered. *PIC* and *your physician* will determine whether any medical care, services, supplies, reimbursement of expenses or payments will be covered. Such care, services, supplies, reimbursement of expenses or payments will not be considered as setting any precedent or creating any future liability.

Other care, treatments, services, or supplies must meet both of these tests:

1. determined in advance by *PIC* to be *medically necessary* and cost effective in meeting *your* long term or intensive care needs in connection with a catastrophic *sickness* or *injury*.
2. charges *incurred* would not otherwise be payable or would be payable at a lesser percentage.

IX. Description of Benefits

1. **Also refer to the Schedule of Payments to help determine *your* benefit level.**
2. **See the Pre-certification Requirement and Prior Authorization Recommendation section for certain services.**
3. **Some rules for obtaining benefits are listed in *your provider* directory.**
4. **Be sure to review the list of Exclusions. A *provider* recommendation or performance of a service, even if it is the only service available for *your* particular condition, does not mean it is a *covered service*. Benefits are not available for *medically necessary* services, unless such services are also *covered services,* and received while *you* are covered under this *contract*.**
5. **Benefits are limited to the most cost effective and *medically necessary* alternative.**

Benefit	***Participating Provider Benefit, PIC* pays*:***	***Non-Participating Provider Benefit, PIC* pays:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value*.
A. Ambulance Services		
Ambulance services for an *emergency*.	80% of *eligible charges* after the *deductible*.	Same as the *participating provider* benefit for *emergency* ambulance services.
Non-*emergency* transportation. **Note:** Non-*emergency* transportation must be pre-certified in advance by *PIC*.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible* for non-*emergency* transportation.

Ambulance services for an *emergency*. *PIC* covers ambulance service and *emergency* transportation to the nearest *hospital* or medical center where initial care can be rendered for a medical *emergency*. Air ambulance is covered only when the condition is an acute medical *emergency* and is authorized by a *physician*. Non-*emergency* transportation must be pre-certified in advance by *PIC*.

PIC covers *emergency* ambulance (air or ground) transfer from a *hospital* not able to render the *medically necessary* care to the nearest *hospital* or medical center able to render the *medically necessary* care only when the condition is a critical medical situation and is ordered by a *physician* and coordinated with a receiving *physician*.

Ambulance services for a non-*emergency*. Non-*emergency* ambulance service, from *hospital* to *hospital* when care for *your* condition is not available at the *hospital* where *you* were first admitted. Transfers from a *hospital* to other facilities for subsequent covered care or from home to *physician* offices or other facilities for outpatient treatment procedures or tests are covered if medical supervision is required en route and when pre-certified. *PIC*'s medical director or designee must pre-certify non-*emergency* ambulance services in advance.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
B. Chiropractic Services		
Services to treat acute musculoskeletal conditions by manual manipulation therapy.	80% of *eligible charges* after the *deductible*.	Not covered.

Diagnostic services are limited to *medically necessary* radiology. Treatment is limited to conditions related to the spine or joints.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Services to treat acute musculoskeletal conditions by manual manipulation therapy when received from a *non-participating provider.*
c. Routine *maintenance care*.
d. Blood, urine or hair analysis.
e. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
f. Manipulation under anesthesia.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:

C. Dental Services		
Accidental Dental Services.	**Note**: Treatment and repair must be completed within twelve months of the date of the *injury*.	
	80% of *eligible charges* after the *deductible*.	Not covered.
Medically Necessary Outpatient Dental Services and Hospitalization for Dental Care.	80% of *eligible charges* after the *deductible*.	Not covered.

This provision does not provide coverage for preventive dental procedures. *PIC* considers dental procedures to be services rendered by a *dentist* or *dental specialist* to treat the supporting soft tissue and bone structure.

PIC covers the following dental services**:**

1. **Accidental Dental Services**. *PIC* covers services to treat and restore damage done to sound, natural teeth as a result of an accidental *injury*. Coverage is for external trauma to the face and mouth only, not for cracked or broken teeth that result from biting or chewing. A sound, natural tooth is a tooth without pathology (including supporting structures) rendering it incapable of continued function for at least one year. Treatment and repair must be started within six months and completed within twelve months of the date of the *injury*.
2. ***Medically Necessary* Dental Services:** *PIC* covers dental services required for treatment of an underlying medical condition (e.g. removal of teeth to complete radiation treatment for cancer of the jaw, cysts, and lesions) and provided by a *dentist* or *dental specialist,* including general anesthesia, regardless of whether the services are provided in a *hospital* or a dental office.
3. ***Medically Necessary* Hospitalization for Dental Care:** *PIC* covers hospitalization for dental care. This is limited to charges *incurred* by a *member* who: (1) is a child under age 5; (2) is severely disabled; or (3) has a medical condition unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/*dentist* or *dental specialist* professional fees are not covered for dental services provided, except as described in item 2 above. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Care must be directed by a *physician* or by a *dentist* or *dental specialist*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Dental services received from a *non-participating provider*.
c. Dental services covered under *your* dental plan.
d. Preventive dental procedures.
e. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
f. Orthodontia and all associated expenses.
g. *Health care services* or dental services for or related to oral surgery and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
h. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
i. Dental implants.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *PIC*.
k. *Health care services* or dental services related to periodontal disease, except as covered under this *contract.*
l. Occlusal adjustment or occlusal equilibration.
m. Treatment of bruxism.
n. Surgical extraction of impacted wisdom teeth, except as above for accidental injury to sound, natural teeth or when required for treatment of an underlying medical condition.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
D. Durable Medical Equipment ("DME") Services, Prosthetics, and Orthotics		
DME and Orthotics.	80% of *eligible charges* after the *deductible*.	Not covered.
Prosthetics.	80% of *eligible charges* after the *deductible*.	Not covered.
Hearing aids for *members* under age 19 for hearing loss that is not correctable by other covered procedures. Coverage limited to one hearing aid per ear every 3 years.	80% of *eligible charges* after the *deductible*.	Not covered.
Wigs for hair loss resulting from alopecia areata are limited to one wig per *calendar year*.	80% of *eligible charges* after the *deductible*.	Not covered.
• Special dietary treatment for phenylketonuria (PKU) is covered when recommended by a *physician*. • Limited coverage for amino-acid based elemental formulas that are consumed orally and treat cystic fibrosis or certain other metabolic and malabsorption errors. • Enteral feedings when they are prescribed by a *physician, physician's* assistant or nurse practitioner and are required to sustain life.	80% of *eligible charges* after the *deductible*.	Not covered.
Diabetic supplies Coverage includes over-the-counter diabetic supplies, including glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary*.	80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers equipment and services ordered by a *physician* and provided by DME/prosthetic/orthotic vendors. For verification of eligible equipment and supplies, contact *PIC* Customer Service at the address and phone number shown on the inside cover of this *contract*. If *you* are over age 18, contact lenses and their related fittings are not eligible for coverage unless they are prescribed as *medically necessary* for the treatment of keratoconus. *Members* must pay for lens replacement.

Amino-acid based elemental formulas are covered only when 1) they are consumed orally, 2) are ordered by a *physician, physician's* assistant, or nurse practitioner for a person who is five years or younger, 3) are *medically necessary*, and 4) treat the following metabolic and other malabsorption conditions that have been diagnosed by a *specialist*: a) cystic fibrosis; b) amino acid, organic acid and fatty acid metabolic and malabsorption disorders; and c) IgE mediated allergies to food proteins, d) eosinophilic esophagitis (EE), e) eosinophilic gastroenteritis (EG), and f) eosinophilic colitis.

Payment is limited to the most cost effective and *medically necessary* alternative. When *you* purchase a model that is more expensive than what is considered *medically necessary* by *PIC*'s medical director or its designee, *you* will be responsible for the difference in purchase and maintenance cost**.** *PIC's* payment for rental shall not exceed the purchase price, unless *PIC* has determined that the item is appropriate for rental only. *PIC* reserves the right for its medical director or designee to determine if an item will be approved for rental or purchase.

If *you* purchase new equipment or supplies when *PIC*'s medical director or designee determines that repair costs of *your* current equipment or supplies would be more cost effective, then *you* will be responsible for the difference in cost.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Any durable medical equipment, supplies, orthotics or prosthetics received from a *non-participating provider*.
c. Any durable medical equipment or supplies not listed as eligible on *PIC's* durable medical equipment list, or as determined by *PIC*.
d. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
e. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
f. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
g. Duplicate or similar items.
h. Hearing aids, devices to improve hearing and related fittings or *health care services*, except as covered under this *contract*.
i. Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
j. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
k. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
l. Over-the-counter orthotics and appliances.
m. Orthopedic shoes and custom molded foot orthotics, unless *you* have diabetes or peripheral vascular disease.
n. Charges for sales tax, mailing and delivery.
o. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
p. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living*.
q. Wigs for conditions other than alopecia areata.
r. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit, PIC* pays**:**
E. *Emergency Services*		
• *Emergency services* provided in an emergency room.	80% of *eligible charges* after the *deductible* for *emergency services*.	Same as the *participating provider benefit*.
• *Emergency services* provided by an immediate response service available on a 24-hour, seven-day-a-week basis for a person having a psychiatric crisis, a mental health crisis or a mental health *emergency*.	80% of *eligible charges* after the *deductible* for *emergency services*.	Same as the *participating provider benefit*.

You should be prepared for the possibility of a medical *emergency* by knowing *your participating provider's* procedures for "on call" and after regular office hours before the need arises. Determine the telephone number to call, which *hospital your participating provider* uses, and other information that will help *you* act quickly and correctly. Keep this information in an accessible location in case a medical *emergency* arises.

If *you* have an *emergency* situation that requires immediate treatment, call 911 or go to the nearest emergency facility. If possible under the circumstances, *you* should telephone *your physician* or the participating clinic where *you* normally receive care. A *physician* will advise *you* how, when and where to obtain the appropriate treatment.

Note: Non-*emergency services* received in an emergency room are not covered. If *you* choose to receive non-*emergency* health services in an emergency room, *you* are solely responsible for the cost of these services. See *emergency* under "Definitions."

You should provide notice to *PIC* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: 1) *you* are physically or mentally unable to provide the required notice; and 2) *you* are unable to provide the notice through another person.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Non-*emergency services* received in an emergency room.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
F. Home Health Services	Limited to 120 home health care visits per *calendar year*. Limited to eight visits for palliative care if *you* are not homebound. Each visit, up to 24-hours in duration, equals one visit and counts toward the maximum visits for home health services. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for home health services. All visits must be *medically necessary* and all charges for home health services must be *eligible charges* under the terms of this *contract*.	
Home health care as an alternative to *hospital confinement* or *skilled nursing facility* care.	80% of *eligible charges* after the *deductible*.	Not covered.
One well-baby home visit by a registered nurse for a mother and newborn child if the inpatient *hospital* stay for the birth of the newborn was less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. This well-baby visit must occur within four calendar days after the date of the well-baby's discharge from the *hospital.* *Health care services* provided by the registered nurse may include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any *medically necessary* clinical tests.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.

NOTE: Benefits for *prescription drugs* administered or received during a home health care visit are described in the "*Prescription Drug* Services" section, except that *prescription drugs* administered by a *participating provider* when it is *medically necessary* that the *provider* administer the *prescription drugs* will be reimbursed at the same rate as applicable to *specialty drugs* received from Fairview Specialty Pharmacy. All terms, conditions, limitations and exclusions described in the "*Prescription Drug* Services" section of this *contract* except the requirement that *specialty drugs* be obtained at Fairview Specialty Pharmacy apply when *prescription drugs* are administered or received during a home health care visit.

PIC covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapeutic services, laboratory services, equipment, supplies and drugs, as appropriate, and other eligible home health services prescribed by a *physician* for the care and treatment of *your sickness* or *injury* and rendered in *your* home up to the visit limits listed above.

You must be *homebound* for care to be received in *your* home, unless *PIC* or its designee deems the care medically appropriate and/or determines that the care is more cost effective than care in a facility or clinic.

A service will not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed, registered nurse. Where a service (such as a tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person, or self-administered, without the direct supervision of a licensed, registered nurse, the service will not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., service, that include skilled and non-skilled components) is covered.

PIC covers palliative care benefits if *you* are not *homebound* up to the visit limit listed above. Palliative care includes symptom management, education, and establishing goals of care.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Home health services received from a *non-participating provider*.
c. Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
d. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
e. *Health care services* and other services that can be performed by a non-medical person or self-administered.
f. Home health aides.
g. *Health care services* and other services provided in *your* home for convenience.
h. *Health care services* and other services provided in *your* home due to lack of transportation.
i. *Custodial care*.
j. *Health care services* and any other services at any site other than *your* home.
k. Recreational therapy.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit:*
G. Hospice Care	80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers hospice services if *you* are terminally ill and accepted into a home hospice program. *You* must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in *your* home, with inpatient care available when *medically necessary* as described below. If *you* elect to receive hospice services, *you* do so in lieu of curative or restorative treatment for *your* terminal illness for the period *you* are enrolled in the home hospice program.

1. **Eligibility.** In order to be eligible to be enrolled in the home hospice program, *you* must:

   a. be terminally-ill with a *physician* certification that *you have* six months or less to live; and

   b. have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than restorative treatment or treatment attempting to cure the disease or condition).

   You may withdraw from the home hospice program at any time.

2. ***Covered Services***. Hospice services include the following services, provided in accordance with an approved hospice treatment plan:

   a. part-time (defined as up to two hours of service per calendar day) care in *your* home by an interdisciplinary hospice team (which might include a *physician*, nurse, social worker, and spiritual counselor) and home health aide services, if prior authorized by *PIC's* medical director or its designee.

   b. one or more periods of continuous care in *your* home or in a setting that provides day care for pain or symptom management, when *medically necessary*, as determined by *PIC*'s medical director or designee.

   c. *medically necessary* inpatient services, when pre-certified by *PIC*'s medical director or designee.

   d. respite care for caregivers in *your* home or in an appropriate setting. Respite care should be prior authorized by *PIC*'s medical director or designee, to give *your* primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain *you* at home. Respite care is limited to five calendar days per episode and respite care and continuous care combined are limited to 30 calendar days while *you* are enrolled in the hospice program.

   e. *medically necessary* medications for pain and symptom management, if prior authorized by *PIC's* medical director or its designee.

   f. *hospital* beds and other durable medical equipment when *medically necessary* and should be prior authorized by *PIC*'s medical director or designee.

   Continuous care is defined as two to 12 hours of service per calendar day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain *you* in *your* home when *you* are terminally ill.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Hospice care received from a *non-participating provider*.
c. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
d. Respite or rest care, except as specifically described in this section.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit, PIC* pays**:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value.*
H. *Hospital* Services		
• Inpatient *Hospital* Services. • Inpatient *hospital* and *residential treatment facility* services for mental and substance use disorders. • Outpatient *hospital* services, ambulatory care or surgical facility services. • Outpatient *hospital*, partial *hospital*, and rehabilitation services in a day *hospital* program for mental and substance use disorders. • Telemedicine. • *Medically necessary* genetic testing determined by *PIC* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*. Coverage for c*onfinements* in non-participating *hospitals* and non-participating *residential treatment facilities* are limited to a combined maximum of 120 calendar days per *member* per *calendar year*.

NOTE: Benefits for *prescription drugs* administered or received in an outpatient setting are described in the "*Prescription Drug* Services" section, except that *prescription drugs* administered by a *participating provider* when it is *medically necessary* that the *provider* administer the *prescription drugs* will be reimbursed at the same rate as applicable to *specialty drugs* received from Fairview Specialty Pharmacy. All terms, conditions, limitations and exclusions described in the "*Prescription Drug* Services" section of this *contract* except the requirement that *specialty drugs* be obtained at Fairview Specialty Pharmacy apply when *prescription drugs* are administered or received in an outpatient setting.

Notify *PIC* of *your* admission to an inpatient facility within 48 hours or as soon as medically possible.

Maternity (professional and *hospital* services for delivery and postnatal care). Each *member confinement*, including that of a newborn child, is separate and distinct from the *confinement* of any other *member*.

1. **Inpatient Services.** *PIC* covers services and supplies for the treatment of acute *sickness* or *injury* that requires the level of care only available in an *acute care facility*. Inpatient services include, but are not limited to:

   a. room and board;
   b. the use of operating rooms, intensive care facilities; newborn nursery facilities;
   c. general nursing care, anesthesia, radiation therapy, physical, speech and occupational therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related *hospital* services;
   d. *physician* and other professional medical and surgical services;
   e. mental health and substance use disorder services, including detoxification services;
   f. diagnostic imaging and laboratory tests and pathology;
   g. for a ventilator-dependent patient, up to 120 hours of services, provided by a private-duty nurse or personal care assistant, solely for the purpose of communication or interpretation for the patient, and
   h. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified *physician* assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistant, certified nurse midwife, or a *physician*.

PIC covers a semi-private room, unless a *physician* recommends that a private room is *medically necessary* and so orders. In the event a *member* chooses to receive care in a private room under circumstances in which it is not *medically necessary*, *PIC*'s payment toward the cost of the room shall be based on the average semi-private room rate in that facility. *PIC's* medical director or designee will determine if a private room meets *medically necessary* criteria.

2. **Outpatient *Hospital*, Ambulatory Surgery Center Care, or Surgical Facility Services.** *PIC* covers the following services and supplies, for diagnosis or treatment of *sickness* or *injury* on an outpatient basis:

   a. use of operating rooms or other outpatient departments, rooms or facilities;
   b. the following outpatient services: general nursing care, anesthesia, radiation therapy, *prescription drugs* or other medications administered during treatment, blood and blood plasma, and other diagnostic or treatment related outpatient services;
   c. laboratory tests, pathology and radiology;
   d. *physician* and other professional medical and surgical services rendered while an outpatient;
   e. mental health and substance use disorder services;
   f. professional medical and surgical services provided by an assistant surgeon, which is defined as a certified *physician* assistant, nurse practitioner, clinical nurse specialist, registered nurse first assistant, certified registered nurse first assistants, certified nurse midwives, or a *physician*;
   g. *Biofeedback*; and
   h. Telemedicine services may include interactive audio and video communications, permitting real time communication between a distant site *provider* of *health care services* and the *member*.

   PIC also covers *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *contract*.

3. **Rehabilitation Services in a Day *Hospital* Program.** *PIC* covers rehabilitation services in a day *hospital* program. Coverage is limited to services for *rehabilitative care* in connection with a *sickness* or *injury*.

4. ***Hospital* or *Residential Treatment Facility* Care for Emotionally Disabled Children.** *PIC* covers *medically necessary* inpatient treatment for emotionally disabled children as diagnosed by a *physician* using criteria utilized by the Minnesota Department of Human Services. This care must be authorized by and arranged through a mental health professional. For treatment provided by a *hospital* or *residential treatment facility*, inpatient coverage for emotionally disabled children is the same as the inpatient benefit. The child through age 18 years of age must be an eligible *dependent* according to the terms of this *contract*.

5. **Treatment of Cleft Lip and Cleft Palate.** *PIC* covers treatment of cleft lip and cleft palate for a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19. Treatment includes orthodontic treatment and oral surgery and dental services directly related to the cleft. If a covered dependent child is also covered under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.

6. **Court-Ordered Services**. *PIC* covers mental health evaluations and treatment ordered by a Minnesota court under a valid court order when the services ordered are covered under this *contract* and:

a. The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* as required by law and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
b. The treatment is provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

PIC must receive a copy of any court order and evaluation. *PIC* or its designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

7. **Substance Use Disorder Treatment by the Department of Corrections.** *PIC* covers substance use disorder treatment provided by the Department of Corrections while *you* are committed to the custody of the Department of Corrections following a conviction for first-degree driving while impaired offense under Minnesota Statute §169A.24 when the *health care services* ordered are *covered services* under this *contract* and:

   a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment that treatment may be appropriate and includes this determination as part of the sentencing order; and
   b. The Department of Corrections makes a determination based on a chemical assessment conducted while *you* are in the custody of the department that treatment is appropriate.

   Substance use disorder treatment provided by the Department of Corrections that meets the above requirements is not subject to a separate medical necessity determination by *PIC*. However, *PIC* must receive a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

   The *PIC non-participating provider reimbursement value* for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by *PIC* to a *participating provider*.

Emergency Services that Lead to an Inpatient Admission

You should provide notice to *PIC* of an *emergency* admission. However, if *you* are incapacitated in a manner that prevents *you* from providing notice of the admission within 48 hours or as soon as reasonably possible, or if *you* are a minor and *your* parent (or guardian) was not aware of *your* admission, then the 48 hour time period begins when the incapacity is removed, or when *your* parent (or guardian) is made aware of the admission. *You* are considered incapacitated only when: 1) *you* are physically or mentally unable to provide the required notice; and 2) *you* are unable to provide the notice through another person.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

When coverage is applicable, under state law, health insurance issuers offering health insurance coverage as specified below may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the health insurance issuer may pay for a shorter stay if the attending *provider* (e.g., *your physician*, nurse midwife, or *physician* assistant), after consultation with and mutual agreement by the mother, discharges the mother or newborn earlier.

Also, health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a health insurance issuer may not require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Travel, transportation, other than ambulance transportation, or living expenses.
c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
d. Non-*emergency* ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
e. *Health care services* to treat conditions *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
f. Orthoptics and surgery for refractive conditions correctable by contacts or glasses, i.e., lasik surgery.
g. *Health care services* for gender reassignment, except when *medically necessary*.
h. Genetic testing and associated *health care services*, except as covered under this *contract.*
i. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
j. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.

k. Autopsies.
l. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
m. *Health care services* or items for personal convenience, such as television rental.
n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
o. Nutritional counseling, except when provided:
    1) During a *confinement*; or
    2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
    3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
    4) As counseling that is treated as a *preventive health care service*.
p. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
r. Counseling, studies, *confinements, health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *PIC*, except as covered under this *contract*.

Benefit	*Participating Provider Benefit, PIC* **pays:**	*Non-Participating Provider Benefit, PIC* **pays:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value.*
I. *Infertility* Services • Diagnostic only	80% of *eligible charges* after the *deductible.*	Same as the *participating provider benefit.*

PIC covers professional services necessary to diagnose *infertility* and the related tests, facility charges, and laboratory work related to the diagnosis. Services for the treatment of *infertility* are not eligible for coverage.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Reversal of voluntary sterilization.
c. Adoption costs.
d. Gamete intrafallopian transfer (GIFT) procedures.
e. Zygote intrafallopian transfer (ZIFT) procedures.
f. Intracytoplasmic sperm injection (ICSI).
g. In-vitro fertilization.
h. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
i. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
j. Sperm, ova or embryo acquisition, retrieval or storage.
k. Drugs for the treatment of *infertility*.
l. Treatment of male and female *infertility* and associated *health care services*.

Benefit	***Participating Provider Benefit, PIC* pays*:***	***Non-Participating Provider Benefit, PIC* pays:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value.*
J. Office Visits		
• *Sickness or injury* – Primary care, *specialist* and other practitioner (nurse, *physician*) office visits related to diagnosis, care or treatment of a medical, mental health or substance use related condition, *sickness* or *injury.* • Telemedicine. • Allergy visits. • Port wine stain elimination or maximum feasible treatment to lighten or remove the discoloration. • *Physician* directed nutritional counseling.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Diagnostic imaging, including magnetic resonance imaging and computing tomography, laboratory tests and pathology.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Surgical Services	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• *Web based (online) care.* • *Convenience Care Center.*	80% of *eligible charges* after the *deductible*.	Not covered.
• *Urgent Care Center*	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.
• Allergy injections with no office visit.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

• *Medically necessary* genetic testing determined by *PIC* to be *covered services*, as described below: ✓ *You* display clinical features, or are at direct risk of inheriting the mutation in question (presymptomatic); and ✓ The result of the test will directly impact the current treatment being delivered to *you*; and ✓ After history, physical examination and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain and a valid specific test exists for the suspected condition.	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

NOTE: Benefits for *prescription drugs* administered or received during an office visit are described in the "*Prescription Drug* Services" section, except that *prescription drugs* administered by a *participating provider* when it is *medically necessary* that the *provider* administer the *prescription drugs* will be reimbursed at the same rate as applicable to *specialty drugs* received from Fairview Specialty Pharmacy. All terms, conditions, limitations and exclusions described in the "*Prescription Drug* Services" section of this *contract* except the requirement that *specialty drugs* be obtained at Fairview Specialty Pharmacy apply when *prescription drugs* are administered or received during an office visit.

PIC covers the professional medical and surgical services of licensed *physicians*, health care *providers* and nurses.

1. Services are provided for the following:
   a. Office visits relating to the diagnosis, care or treatment of a condition, *sickness* or *injury*.
   b. Treatment of diagnosed Lyme disease.
   c. Contact lenses and their related fittings are not eligible for coverage for adults over age 18 unless they are prescribed as *medically necessary* for the treatment of keratoconus. If prescribed for keratoconus, *your* first set of contact lenses and their fitting are *eligible charges* under the DME benefit. *You* must pay for lens replacement.
   d. Diagnostic imaging (such as X rays, CT/PET scans, MRIs), laboratory tests, and pathology.
2. Outpatient professional services for evaluation, diagnosis, crisis intervention, therapy, including *medically necessary* group therapy, psychiatric services, treatment of a minor (including family therapy but only for treatment of a minor), and treatment of mental and nervous disorders.
3. Diagnosis and treatment of substance use disorders, including evaluation, diagnosis, therapy and psychiatric services.
4. Port wine stain elimination or maximum feasible treatment to lighten or remove discoloration.
5. Allergy testing and injections.
6. Surgical services performed in the office, including but not limited to:
   a. Oral surgery for: 1) treatment of oral neoplasms and non-dental cysts; 2) fracture of the jaws; 3) trauma of the mouth and jaws; and 4) any other oral surgery procedures provided as *medically necessary* dental services.
   b. Surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) that is *medically necessary*.
7. Treatment of cleft lip and cleft palate for a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19. Treatment includes orthodontic treatment and oral surgery and dental services directly related to the cleft. If a covered dependent child is also covered under a dental plan which covers orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same conditions and limitations as durable medical equipment.
8. Treatment of diagnosed diethylstilbestrol (DES) exposure.

9. Diabetic outpatient self-management training and education, including medical nutrition therapy received from a *provider* working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

10. An *emergency* examination of a child ordered by judicial authorities.

11. Court-Ordered Services. *PIC* covers mental health evaluations and treatment ordered by a Minnesota court under a valid court order when the services ordered are covered under this *contract* and:
    a. The court-ordered behavioral care evaluation is performed by a *participating provider* or other *provider* as required by law and the *provider* is a licensed psychiatrist, or doctoral level licensed psychologist.
    b. The treatment is provided by a *participating provider* or other *provider* as required by law and is based on a behavioral care evaluation that meets the criteria of a. above and includes a diagnosis and an individual treatment plan for care in the most appropriate and least restrictive environment.

    PIC must receive a copy of any court order and evaluation. *PIC* or its designee may make a motion to modify a court ordered plan and may request a new behavioral care evaluation.

12. *Biofeedback*.

13. Telemedicine services may include interactive audio and video communications, permitting real time communication between a distant site *provider* of *health care services* and the *member*, who is present and participating in the televideo visit at a remote *provider* office.

14. Treatment for *pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)* and for *pediatric acute-onset neuropsychiatric syndrome (PANS)*, including behavioral therapies to manage neuropsychiatric symptoms.

PIC also covers *preventive health care services*. These services will be covered as shown in the *Preventive Health Care Services*, and/or the Preventive Contraceptive Methods and Counseling for Women sections of this *contract* and not this section of the *contract*.

Exclusions:

a. Please see the section entitled Exclusion List.
b. Health education, except when:
    1) Provided during an office visit for non-*preventive health care services*; or
    2) It is counseling that is treated as a *preventive health care service*.
c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
d. Nutritional counseling, except when provided:
    1) During a *confinement*; or
    2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
    3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
    4) As counseling that is treated as a *preventive health care service*.
e. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
f. Professional sign language and foreign language interpreter services in a *provider's* office.
g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *PIC*.
i. Genetic testing and associated *health care services*, except as covered under this *contract*.
j. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
k. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
l. Treatment of cleft lip and cleft palate, except for such treatment of a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19.
m. Vision therapy/Orthoptics.
n. *Health care services* provided by an audiologist that are not provided in an office setting.

o. Counseling, studies, or services ordered by a court or law enforcement officer that are not determined to be *medically necessary*, except as covered under this *contract.*
p. Nutritional and food supplements, except as covered under this *contract*.

Benefit	*Designated Transplant Network Provider, PIC* pays:	Non-*Designated Transplant Network Provider*
K. Organ and Bone Marrow *Transplant Services*	Office visits: 80% of *eligible charges* after the *deductible*. *Hospital* services: 80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers eligible *transplant services* that *PIC*'s medical director or designee pre-certifies and determines in advance to be *medically necessary* and not *investigative* but only when the *transplant services* are received at a *designated transplant network provider*.

Coverage for organ transplants, bone marrow transplants, and bone marrow rescue services is subject to periodic review. *PIC* evaluates *transplant services* for therapeutic treatment and safety. This evaluation continues at least annually or as new information becomes available and it results in specific guidelines about benefits for *transplant services*. *You* may call *PIC* at the telephone number listed inside the cover of this *contract* for information about these guidelines.

Benefits, if the transplant meets the definition of an *eligible charge*, is *medically necessary*, and not *investigative*, are available for the following eligible transplants:

1. Bone marrow transplants and peripheral stem cell transplants.
2. Heart transplants.
3. Heart/lung transplants.
4. Lung transplants.
5. Kidney transplants.
6. Kidney/pancreas transplants.
7. Liver transplants.
8. Pancreas transplants.
9. Small bowel transplants.

Transplant coverage includes a private room and all related post-surgical treatment and drugs. The transplant-related treatment provided shall be subject to and in accordance with the provisions, limitations and other terms of this *contract.*

Medical and *hospital* expenses of the donor are covered only when the recipient is a *member* and the transplant has been pre-certified in advance by the medical director or designee. Treatment of medical complications that may occur to the donor are not covered.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Transplant services* received from a *provider* that is not a *designated transplant network provider*.
c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by *PIC*.
e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.
f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
g. Treatment of medical complications to a donor after procurement of a transplanted organ.
h. Computer search for donors.
i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services*.
j. Travel expenses related to a covered transplant.

k. *Health care services* for or in connection with fetal tissue transplantation, except for non-investigative stem cell transplants.
l. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
L. Physical Therapy, Occupational Therapy and Speech Therapy		
Physical Therapy, Occupational Therapy and Speech Therapy.	80% of *eligible charges* after the *deductible*.	Not covered.
• Sensory integration therapy for the treatment of feeding disorders up to 8 visits.	80% of *eligible charges* after the *deductible*.	Not covered.
• Services to treat acute musculoskeletal conditions by manual manipulation therapy.	80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers office visits and outpatient physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for *rehabilitative care* rendered to treat a medical condition, *sickness* or *injury*, and the *rehabilitative care* is expected to demonstrate measurable and sustainable improvement within 2 weeks to 3 months, depending on the physical and mental capacities of the individual. *PIC* also covers office visits and outpatient PT, OT and ST *habilitative therapy* for medically diagnosed conditions. PT, OT and ST must be provided by or under the direct supervision of a licensed physical therapist, occupational therapist or speech therapist for appropriate services within their scope of practice. OT and ST must be ordered by a *physician*, *physician's* assistant or certified nurse practitioner.

NOTE: Benefits for *health care services* administered or received in an inpatient setting are described in the "*Hospital* Services" section of this *contract.* Benefits for *skilled care* administered or received in a *skilled nursing facility* are described in the "*Skilled Nursing Facility* Care" section of this *contract*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Physical therapy, occupational therapy and speech therapy received from a *non-participating provider*.
c. *Custodial care* or *maintenance care*.
d. Therapy provided in *your* home for convenience.
e. Therapy for conditions that are self-correcting.
f. Voice training and voice therapy absent a medical condition.
g. *Investigative* therapies.
h. Group therapy for physical therapy, occupational therapy and speech therapy.
i. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
j. Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
k. *Health care services* for homeopathy and immunoaugmentive therapy.

Benefits	Drugs obtained at a pharmacy that is a *participating provider*. *PIC* pays:	Drugs obtained at a pharmacy that is not a *participating provider*:
M. *Prescription Drug* Services	**Note:** Benefits for *specialty drugs* and injectable drugs that are not *specialty drugs*, excluding insulin, are as described in this section regardless of the place of service where the *specialty drug* or injectable drug that is not a *specialty drug* is dispensed or administered. Please see the *Preventive Health Care Services* section for coverage of *prescription drugs*, including certain insulin and other glucose lowering agents, on *PIC's* Preventive Drug List. Drugs identified for *our* Split Fill Program may be provided in a 7 or 15 calendar day supply per prescription or refill even if prescribed for 31 calendar days. For a list of drugs on the Split Fill Program go to the *member* site on www.preferredone.com or call Customer Service.	
• *Prescription drugs* that can be self-administered for up to a 31-calendar day supply per prescription or refill.	**Tier 1 Generic:** 80% of *eligible charges* after the *deductible*. **Tier 2 Generic:** 80% of *eligible charges* after the *deductible*. **Preferred Brand:** 80% of *eligible charges* after the *deductible*. **Non-Preferred Brand and Non-*formulary*:** Not covered.	Not covered.
• Mail order *prescription drugs* for up to a 31-calendar day supply per prescription or refill.	**Tier 1 Generic:** 80% of *eligible charges* after the *deductible*. **Tier 2 Generic:** 80% of *eligible charges* after the *deductible*. **Preferred Brand:** 80% of *eligible charges* after the *deductible*. **Non-Preferred Brand and Non-*formulary*:** Not covered.	Not covered.
• Diabetic supplies, including over-the-counter diabetic supplies, including glucose monitors, syringes, blood and urine test strips, and other diabetic supplies as *medically necessary*.	80% of *eligible charges* after the *deductible*.	Not covered.

• Injectable drugs up to a 31–calendar day supply per prescription or refill, except *specialty drugs*, women's contraceptives, and insulin. **NOTE:** Injectable drugs, except insulin, will not be covered at the tier 1 generic, tier 2 generic, preferred brand or mail order benefit level.	**Tier 1 Generic:** 50% of *eligible charges* after the *deductible*. **Tier 2 Generic:** 50% of *eligible charges* after the *deductible*. **Preferred Brand:** 50% of *eligible charges* after the *deductible*. **Non-Preferred Brand and Non-*formulary*:** Not covered.	Not covered.

Specialty Drugs		
Benefits	***Specialty Drugs* obtained at Fairview Specialty Pharmacy or other designated specialty pharmacy. *PIC* pays:** For more information, contact Fairview Specialty Pharmacy at 612.672.5260 or 1.800.595.7140. **NOTE:** Certain *specialty drugs* may only be available by limited distribution through the manufacturer's select specialty pharmacy and may not be available through Fairview Specialty Pharmacy. Benefits for such limited distribution *specialty drugs* will be paid the same as if they were obtained from Fairview Specialty Pharmacy.	***Specialty Drugs* obtained at any pharmacy other than a designated specialty pharmacy:**

• *Specialty drugs* up to a 31–calendar day supply per prescription or refill that: ✓ may be oral or injectable; and ✓ Must be purchased through a specialty pharmacy. A list of these *specialty drugs* may be obtained on *PIC*'s website or by calling *PIC* Customer Service. The list of *specialty drugs* may be revised from time-to-time without notice. **NOTE:** *Prescription drugs* which *PIC* determines are *specialty drugs* will not be covered at the tier 1 generic, tier 2 generic, preferred brand or mail order benefit level.	**Tier 1 Generic:** 50% of *eligible charges* after the *deductible*. **Tier 2 Generic:** 50% of *eligible charges* after the *deductible*. **Preferred Brand:** 50% of *eligible charges* after the *deductible*. **Non-Preferred Brand and Non-*formulary*:** Not covered.	Not covered.

Preventive Contraceptives. This section does not cover or provide benefits for oral, injectable, insertable, *prescription drugs* and devices that are *preventive health care services* described in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*

Formulary. *PIC* uses its drug *formulary* to determine which benefit level applies to a specific *prescription drug*. The *formulary* is subject to periodic review by *PIC*'s Pharmacy and Therapeutics Quality Subcommittee and modification by *PIC,* including at the start of or during the plan year. A current list of drugs on *PIC*'s *formulary* for individual plans may be obtained by accessing *PIC*'s website at https://www.preferredone.com/pharmacy-information/formulary and choosing "Individual Plans" or by calling *PIC* Customer Service. *PIC* will provide reasonable advance notice to *you* if, during the plan year, a *prescription drug* which *you* have previously received during such plan year and which *PIC* has previously considered to be an *eligible charge* under this *contract* is removed from the *formulary* or if such *prescription drug* is placed in a higher cost-sharing tier during the plan year. *You* have a right to appeal the decision or to request an exception to gain access to a non-*formulary* drug when clinically appropriate and not otherwise covered under this *contract*. Refer to the section entitled "Internal Appeals Process" for details on how to appeal. Refer to the paragraphs entitled "Exceptions" below for details on how to request an exception.

Step Therapy. For certain medical conditions, there is a need to manage the use of specific drugs before alternative (second line) drugs are prescribed for the same medical condition. This is known as step therapy. *Members* in a step therapy program will need to meet the requirements of that program prior to receiving the second line drug. *You* may learn more about the program requirements by calling *PIC* Customer Service or *you* can access information about step therapy at https://www.preferredone.com/pharmacy-information/formulary and choose "Individual Plans". Step therapy can apply to *formulary* or non-*formulary* drugs and brand or generic drugs. The Step Therapy List is subject to periodic review and modification by *PIC.*

Quantity Limits. Some dispensed *prescription drugs* require the use of quantity limits, which ensure that the quantity of each prescription remains consistent with clinical guidelines. Quantity limits can apply to *formulary* or non-*formulary* drugs, and brand or generic drugs. A list of those *prescription drugs* with quantity limits is available upon request. The quantity limits list is subject to periodic review and modification by *PIC.*

Eye Drop Refills. Refills of prescribed eye drops are covered if the refill is requested by the *member* covered under this *contract* and the prescribing *provider* indicates that refills are required. Coverage for such eye drops will only be provided if *you* make a refill request for a 31-day refill supply and the request is made between 21 and 31 days from the later of the original date the prescription was dispensed or the date of the most recent refill.

Brand Name Drugs for which Generic Available. If *you* or *your provider* request a brand name drug when a generic drug alternative is available, *you* must pay the applicable *coinsurance* for the brand name drug plus the difference in cost between the brand name and the generic drug.

Manufacturer's Support Programs: For brand name *prescription drugs* that do not have an available and medically appropriate generic equivalent, amounts paid using any form of direct support offered to *you* by drug manufacturers to reduce or eliminate immediate out-of-pocket costs will be counted towards the "maximum-out-of-pocket" limitation set forth in the *Affordable Care Act* (and without regard to the *out-of-pocket limit* under this *contract).* For any *prescription drugs* that are generic or have an available and medically appropriate generic equivalent, amounts paid using any form of direct support offered to *you* by drug manufacturers to reduce or eliminate immediate out-of-pocket costs, will not be counted towards *your deductible, coinsurance* or *out-of-pocket limit* under this *contract.*

Biosimilar Drugs. If all of the following apply:

1. *you* or *your provider* request a *specialty drug* that is a biological product licensed by the FDA under section 351 of the Public Health Service Act (PHS Act), and
2. the FDA has determined another biological product to be biosimilar to the *specialty drug* that has been requested by *your provider*, and
3. *PIC* has included such biosimilar drug on its list of approved biosimilar drugs in relation to the *specialty drug* that has been requested by *your provider*.

then *you* must pay the applicable *deductible* or *coinsurance* for the *specialty drug* requested by *your provider* plus the difference in cost between the *specialty drug* requested by *your provider* and the biosimilar product that is on *PIC's* list of approved biosimilar drugs.

Exceptions: *You* or *your provider* may request an exception to the drug *formulary. PIC* must make a determination on a standard exception request and notify *you* and the prescribing *physician* of *PIC's* coverage determination no later than 72 hours following receipt of the request. Upon request, *PIC* will perform an expedited review of the exception request if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function,

or when *you* are undergoing a current course of treatment using a non-*formulary* drug. If *PIC* determines *you* qualify for an expedited review of the exception request based on these criteria, *PIC* must make a determination on the expedited exception request and notify *you* and the prescribing *physician* of *PIC's* coverage determination no later than 24 hours following receipt of the request. *PIC* will determine if an exception applies and, if so, the non-*formulary* drugs that are approved as an exception will be covered at the same level as the *formulary* drugs.

If *your* request for a *formulary* exception is denied, *you* have a right to request that *your formulary* exception request be reviewed by an independent review organization that is not associated with *PIC.* This right to request external review of a *formulary* exception request is separate from *your* right to request external review as described in the External Review Process section and only applies to denials of a *formulary* exception request and only after *your formulary* exception request has been reviewed in accordance with the preceding paragraph and denied. When *you* request an external review of a *formulary* exception request, *you* will be required to authorize release of any medical records that the independent review organization might need to review for the purpose of reaching a decision. If *your formulary* exception request is complete and eligible for external review, *PIC* will notify *you* which independent review organization will conduct the external review. *You* will then receive more detailed information, including contact information for the independent review organization. If the original *formulary* exception request was a standard exception request, *you* will be notified of the results of the external review within 72 hours following receipt of the request. If the original *formulary* exception request was an expedited exception request, *you* will be notified of the results of the external review within 24 hours following receipt of the request.

An exception is valid for the duration of the prescription while covered under this *contract,* including refills, except that if *you* obtained an exception based on an expedited review the exception will be valid for the duration of the circumstances that are the basis for the expedited review. *Your physician* may request the exception for subsequent prescriptions, following the procedure described above. The exception does not apply if *PIC* removed the drug from the *formulary* for safety reasons. Contact *PIC* Customer Service for a copy of the written guidelines and procedures, or for assistance in requesting an exception.

Antipsychotic Drugs: Exceptions to the drug *formulary* are also available in certain circumstances as required by Minnesota Statute 62Q.527 if *you* receive an antipsychotic drug to treat a diagnosed mental illness or emotional disturbance. *PIC* will continue to cover the drug, as though it were a *formulary* drug for up to one year after it is removed from the *formulary*, unless it was removed from the *formulary* due to safety reasons, or *you* change health plans and become covered under this *contract*, provided the drug has been shown to effectively treat *your* illness or disturbance and the following conditions are met:

1. *You* were treated with the drug for 90 calendar days before a change in *PIC's formulary* or a change in *your* health plan,
2. *Your physician* designates that the prescription must be dispensed as communicated, and
3. *Your physician* certifies in writing to *PIC* that the *prescription drug* will best treat *your* condition.

An exception to the drug *formulary* for an antipsychotic drug to treat a diagnosed mental illness or emotional disturbance which was initially provided under the paragraph above will be extended annually when the following conditions are met:

1. *your physician* indicates to the dispensing pharmacist, orally or in writing, that the *prescription drug* must be dispensed as communicated; and
2. *your physician* certifies in writing to *PIC* that the drug prescribed will best treat *your* condition.

Compounded Drugs. *Compounded drugs* will be covered only if obtained from Fairview Compounding Pharmacy or other designated compounding pharmacy provided that at least one active ingredient is a *prescription drug*. Payment for a *compounded drug* that has a commercially prepared product available that is identical to or similar to the *compounded drug* will be considered for coverage after documented failure of the commercially prepared product(s), unless a *formulary* exception is obtained. A commercially prepared product is one that is available at the pharmacy in its final, usable form and does not need to be compounded at the pharmacy. The applicable *formulary* benefit level will be applied. *Compounded drugs* containing any product that is excluded by *PIC* will not be covered, including dosages and route of administration that have not been approved by the FDA.

Prescription Drugs* covered as *Preventive Health Care Services. *PIC* covers certain *prescription drugs* which are required to be covered without cost-sharing as *preventive health care services* under the *Affordable Care Act. PIC*'s *formulary* identifies these *prescription drugs* as being included in the "$0 Cost Share" tier and may be obtained by accessing *PIC*'s website at https://www.preferredone.com/pharmacy-information/formulary and choosing "Individual Plans" or by calling *PIC* Customer Service. More information regarding benefits for *prescription drugs* that are *preventive health care services* can be found under the "Preventive Contraceptive Methods and Counseling for Women" and "*Preventive Health Care Services*" sections of this *contract.*

Off-label use of drugs. Off-label use of drugs, provided they are not *investigative,* are covered when:

1. A drug is recognized as appropriate for cancer treatment in a *standard reference compendia* such as the National Comprehensive Cancer Network Drugs and Biologics Compendium or one article in the *medical literature*; or
2. A drug is deemed appropriate for its proposed use by any authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case-reports.

Cancer Chemotherapy. *PIC* will not require a higher *deductible, or coinsurance* amount for an anticancer *prescription drug* used to kill or slow the growth of cancerous cells that is orally-administered than for an anticancer *prescription drug* that is injected or intravenously-administered.

PANDAS/PANS. *PIC* covers treatment for *pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)* and for *pediatric acute-onset neuropsychiatric syndrome (PANS)*, including antibiotics, medication to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Prior Authorization. Certain *prescription drugs* may require prior authorization before *you* can have *your* prescription filled at the pharmacy. For information, *you* may call *PIC* at the phone number listed on the inside front cover of this *contract*. These *prescription drugs* may include, but are not limited to:

1. *prescription drugs* that are over:
   a. $200 if a *compounded drug*;
   b. $1,500 if a retail prescription; or
   c. $2,500 if a mail order prescription. and
2. *specialty drugs.*

For more information call *PIC* at the phone number listed on the inside front cover of this *contract.*

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
c. Replacement of a *prescription drug* due to loss, damage, or theft.
d. Drugs available over-the-counter (OTC), except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *contract*.
e. *Prescription drugs* equivalent to or similar to OTC drugs, except as covered under this *contract*.
f. OTC home testing products, except as covered under this *contract*.
g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *PIC*, at its sole discretion, determines to include the drug on its *formulary* or approves coverage of the drug for the particular use.
h. Take home drugs when dispensed by a *physician*.
i. Weight loss drugs.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract*.
k. Drugs used for *cosmetic* purposes.
l. Unit dose packaging.
m. *Prescription drugs* for the treatment of *infertility*.
n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use, but is being applied topically).
o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
p. *Prescription drugs* if purchased by mail order through a program not administered by *PIC's* pharmacy vendor.
q. *Prescription drugs* for the treatment of sexual dysfunction.
r. Off-label use of drugs, determined to be *investigative*.
s. Certain *combination drugs* and other drugs, regardless of *formular*y status will not be covered according to *PIC*'s pharmacy policy titled Cost Benefit Program. Contact *PIC* Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.
t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this *contract*.
u. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*

v. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services.*
w. *Specialty drugs* obtained at any pharmacy other than Fairview Specialty Pharmacy or other designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through Fairview Specialty Pharmacy.
x. *Compounded drugs* obtained from any pharmacy other than Fairview Compounding Pharmacy or another designated compounding pharmacy.
y. Non-*formulary* drugs, unless an exception is obtained from *PIC.*
z. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *contract*, except as required under state or federal law.

Benefit	*Participating Provider Benefit, PIC* **pays:**	*Non-Participating Provider Benefit, PIC* **pays:**
		Note: For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value.*

N. Preventive Contraceptive Methods and Counseling for Women

PIC covers preventive contraceptive methods and counseling services received during the *calendar year* by female *members* as described in the Preventive Health Care Services Schedule ("Schedule") and according to the frequency and time frames stated in the Schedule.

The Schedule, which includes the preventive contraceptive methods and counseling services for women provided by the *Affordable Care Act*, is available on *PIC's member* website or by calling *PIC* Customer Service.

This coverage includes the full range of Food and Drug Administration approved contraceptive methods for women with reproductive capacity, including women's contraceptive drugs, devices, and delivery methods obtained from a retail pharmacy, a mail order pharmacy, or received at a *provider's* office.

Women's prescription contraceptives received at a retail pharmacy or mail order pharmacy:

• Generic oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• Brand name oral, injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	**Preferred Brand:** 80% of *eligible charges* after the *deductible.* **Non-Preferred Brand and Non-*formulary*:** Not covered.	Not covered.

Women's prescription contraceptives, sterilization procedures, and *member* education received at a *provider's* office:

• Generic injectable, implantable, and insertable contraceptives that require a prescription under applicable law; and • Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which no generic alternative exists.	100% of *eligible charges.* *Deductible* does not apply.	Not covered.

• Brand name injectable, implantable, and insertable contraceptives that require a prescription under applicable law, and for which a generic alternative exists.	80% of *eligible charges* after the *deductible.*	Not covered.
• Sterilization procedures, excluding the reversal of sterilization procedures.	100% of *eligible charges. Deductible* does not apply.	Not covered.
• *Member* education and counseling about contraceptive methods.	100% of *eligible charges. Deductible* does not apply.	Same as the *participating provider* benefit.

Your provider may request an exception for coverage with no cost sharing for a brand name drug for which a generic drug is available. *Your provider* or *you* may contact *PIC* Customer Service for a copy of the written guidelines and procedures or for assistance in requesting an exception.

If the exception is approved, *PIC* will pay 100% of the *eligible charges* for the brand name preventive contraceptive drug when *you* obtain it from a *participating provider*, and the *deductible* will not apply.

An exception is valid for the duration of the prescription while you are covered under this *contract*, including refills. *Your provider* may request an exception for subsequent prescriptions following the procedure described in the *Prescription Drug* Services section. The exception does not apply if *PIC* removes the drug from the *formulary* for safety reasons. A previously granted exception ends when *PIC* removes the drug from the *formulary* for safety reasons.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Contraceptives and related *health care services* received from *non-participating providers*, except *member* education and counseling about contraceptive methods.
c. Sterilization procedures performed by *non-participating providers*.
d. Abortions are not covered under this section of this *contract*.
e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
f. Hysterectomies are not covered under this section of this *contract*.
g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures, such as but not limited to Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *contract*.
h. Reversal of sterilization procedures.
i. Non-*preventive health care services* are not covered under this section of this *contract*.

Benefit	***Participating Provider Benefit, PIC* pays*:***	***Non-Participating Provider Benefit*:**
O. *Preventive Health Care Services*		
PIC covers *preventive health care services* required under the *Affordable Care Act* that *you* receive during the *calendar year*. The services required by the *Affordable Care Act* and their frequency and time frames are stated in the *Preventive Health Care Services* Schedule ("Schedule"). The Schedule may be amended from time-to-time, on a prospective basis, and is available on *PIC's member* website at www.preferredone.com or by contacting *PIC* Customer Service. This *contract* also covers certain *preventive health care services* that are required by state law. They are addressed at the end of this section.		
The Schedule includes certain routine services such as: • Counseling for certain conditions and lactation counseling. • Routine immunizations • Routine laboratory tests, pathology and radiology. • Routine physical examinations when ordered by a *physician*. • Purchase/rental of breast pumps. • Certain prescribed preventive medications required under the *Affordable Care Act*. • Routine screenings for certain cancers (such as Pap tests, colorectal screening tests for men and women including colonoscopy and associated *medically necessary health care services* and mammograms including digital breast tomosynthesis for *members* at risk for breast cancer as required under Minnesota Statute 62A.30). • Routine screenings for other conditions (such as abdominal aortic aneurysm, diabetes, HIV and osteoporosis). **Note:** If any of the services listed above are prenatal or child health supervision services, see below for further benefit information.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.

• Tobacco cessation intervention programs: - Two designated tobacco cessation counseling program attempts per *member* per *calendar year*, limited to four counseling sessions per attempt; - Tobacco cessation *prescription drugs* and prescribed over-the-counter (OTC*)* medications when used in connection with or separate from a designated tobacco cessation counseling program, are limited to a maximum of 31-calendar days per prescription or refill per *member* and a total 93-calendar day supply per *member* per attempt for up to two attempts per *member* per *calendar year*.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• Routine screening tests and counseling for pregnant women and associated visits.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.

Preventive Health Care Services that are in Addition to Those Required by the *Affordable Care Act*

• Routine hearing examination limited to one exam per *member* per *calendar year*.	80% of *eligible charges* after the *deductible.*	Not covered.
• Surveillance tests for ovarian cancer for women, including CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests for women who are at risk for ovarian cancer due to family history or testing positive for BRCA1 or BRCA2 mutations. • Prostate-specific antigen blood tests and digital rectal examinations to screen for prostate cancer for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.	80% of *eligible charges* after the *deductible.*	Not covered.

• Insulin or other glucose lowering agent on *PIC's* Preventive Drug list for up to a 31-calendar day supply for one type of insulin or other glucose lowering agent per prescription or refill. **Cost-Sharing Limits for Insulin.** Cost sharing (i.e. *copayment)* for insulin is limited to the *net price* of the insulin.	100% of *eligible charges* after a *copayment* of $25 per 31-calendar day prescription or refill. *Deductible* does not apply.	Not covered.

• Other preventive drugs on *PIC's* Preventive Drug list, including:
  • Angiotensin converting enzyme (ACE) inhibitors for congestive heart failure, diabetes, and/or coronary artery disease.
  • Beta-blockers for congestive heart failure and/or coronary artery disease.
  • Selective Serotonin Reuptake Inhibitors (SSRIs) for depression.
	100% of *eligible charges* per 31-calendar day prescription or refill. *Deductible* does not apply.	Not covered.

• Routine prenatal care services (as defined below)	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• One routine postnatal care exam that includes a health exam, assessment, education and counseling provided during the period immediately after childbirth.	100% of *eligible charges*. *Deductible* does not apply.	Not covered.
• Child health supervision services (as defined below).	100% of *eligible charges*. *Deductible* does not apply.	Not covered.

Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education and use of routine specialized skills and technology as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists and as required by state law.

Child health supervision services includes pediatric preventive services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six and appropriate immunizations up to age 18. Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.

Female *members* may obtain annual preventive health examinations and prenatal care from *specialists* such as obstetricians and gynecologists in the *participating provider* network, without a referral from another *physician* or prior approval from *PIC* or its designees.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Preventive health care services* under this section of this *contract* received from a *non-participating provider*.

c. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract*.
d. Routine eye examinations, except as otherwise covered under this *contract*.
e. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
f. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *contract.*
g. Non-*preventive health care services* are not covered under this section of this *contract*.
h. Non-routine *health care services*, including but not limited to non-routine prenatal services, are not covered under this section of this *contract*.
i. Non-prescribed over-the-counter medications.

Benefit	***Participating Provider Benefit, PIC* pays*:***	***Non-Participating Provider Benefit, PIC* pays:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value.*
P. *Reconstructive* Surgery	80% of *eligible charges* after the *deductible*.	50% of *eligible charges* after the *deductible*.

PIC covers *medically necessary reconstructive* surgery due to *sickness*, accident or congenital anomaly. *Eligible charges* include eligible *hospital*, *physician*, laboratory, pathology, radiology and facility charges. Contact *PIC* Customer Service to determine if a specific procedure is covered.

PIC also covers *reconstructive surgery following a mastectomy. Reconstructive surgery following a mastectomy* includes the following:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Services and supplies will be determined in consultation with the attending *physician* and patient. Such coverage will be subject to *coinsurance* and other plan provisions.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. *Health care services* to treat conditions that are *cosmetic* in nature.

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
Q. *Skilled Nursing Facility* Care		
Skilled rehabilitation, including room and board.	80% of *eligible charges* after the *deductible*.	Not covered.
Daily *skilled care* as an alternative to *hospital confinements.*	80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers the eligible *skilled nursing facility* services for post-acute treatment and *rehabilitative care sickness* or *injury*. These services must be directed or referred by a *physician* and pre-certified by *PIC's* medical director or designee.

Skilled nursing facility services include room and board, daily skilled nursing and related ancillary services.

PIC covers a semi-private room unless a *physician* recommends that a private room is *medically necessary* and so orders. *PIC's* medical director or designee determines if a private room is *medically necessary*. In the event a *member* chooses to receive care in a private room under circumstances in which it is not *medically necessary*, *PIC*'s payment toward the cost of the room shall be based on the average semi-private room rate in that facility. Only services that qualify as reimbursable under Medicare are covered benefits, and coverage is limited to the maximum number of calendar days per *calendar year* if the services would qualify as reimbursable under Medicare.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Skilled nursing facility care received from a *non-participating provider*.
c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
d. Respite or *custodial care*.

Benefit	***Participating Provider Benefit, PIC* pays*:***	***Non-Participating Provider Benefit, PIC* pays:** **Note:** For *non-participating providers*, in addition to any *deductibles* and *coinsurance*, *you* pay all charges that exceed the *PIC non-participating provider reimbursement value*.

R. Specified *Non-Participating Provider* Services

The services listed below are covered at the same benefit level as the type of service benefit shown in the schedule above for *participating provider* benefits. *You* are not required to receive these services from a *participating provider*. For example, an office visit (whether by a *participating provider* or a *non-participating provider*) for the services listed below will be covered at the *participating provider* benefit level.

1. Voluntary family planning of the conception and bearing of children.
2. The *provider* visit(s) and test(s) necessary to make a diagnosis of *infertility*.
3. Testing for sexually transmitted diseases, AIDS, and other HIV-related conditions.
4. Treatment of sexually transmitted diseases, except AIDS and other HIV-related conditions.

Exclusions:

a. Please see the section entitled "Exclusion List."

Benefit	*Participating Provider Benefit, PIC* pays*:*	*Non-Participating Provider Benefit*:
S. Vision Care – Pediatric		
• Exam (one per *calendar year*).	100% of *eligible charges.* *Deductible* does not apply.	Not covered.
• *Medically necessary* polycarbonate lenses with scratch coating (one pair per *calendar year*). • Conventional contact lenses to correct visual acuity limitations, in lieu of *medically necessary* eyeglasses. Coverage is limited to one pair of conventional contact lenses per *calendar year* or one 12-month series of planned replacement lenses per *calendar year*. Notwithstanding any other provisions of the *contract*, contact lenses for children under age 19 are covered whenever *medically necessary*. • Bandage/therapeutic contact lenses. • Frames (standard frames, as required, to hold the lenses in front of the eyes and supported by the bridge of the nose, one pair per *calendar year*). • *Medically necessary* low vision services. • *Medically necessary* optional lenses and treatments.	80% of *eligible charges* after the *deductible*.	Not covered.

PIC covers *medically necessary* vision services and materials described above for, or related to, routine eye exams, lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, through the end of the month in which the *member* reaches age 19. Payment is limited to the most cost effective and *medically necessary* alternative. When *you* purchase lenses, frames or optical devices that are more expensive than what is considered *medically necessary* by *PIC*'s medical director or its designee, *you* will be responsible for the difference in purchase and maintenance cost**.** For information regarding whether any optical device or professional service is *medically necessary*, call *PIC* Customer Service.

PIC also covers *preventive health care services*, including routine screening to detect amblyopia or its risk factors in children ages 3-5. These services will be covered as shown in the *Preventive Health Care Services* section of this *contract* and not this section of the *contract*.

Exclusions:

a. Please see the section entitled "Exclusion List."
b. Vision care received from a *non-participating provider*.
c. Vision care received after the end of the month in which the *member* reaches age 19.
d. Lenses, frames or optical devices not *medically necessary*.
e. *Health care services* or materials not meeting the standards of accepted optometric practices.
f. Repairs to frames and lenses.
g. Vision therapy.

h. Frames that are brand name or mid to high-end fashion frames.
i. Replacement of stolen or lost eyewear.
j. Non-prescription lenses, including reading glasses without a prescription.
k. Two pairs of eyeglasses in lieu of bifocals.
l. Elective lenses, including, but not limited to, toric, gas permeable and bifocal contact lenses.
m. Insurance of contact lenses
n. Saline or other solutions for the care of contact lenses.
o. Prosthetic devices and associated *health care services*.
p. Sunglasses.
q. Sport lenses and sport frames.
r. Special lens designs or coatings not *medically necessary*, including but not limited to special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
s. Replacement of lenses or frames due to *provider* error in prescribing, frame selection or measurement. The *provider* making the error is responsible for bearing the cost of correcting the error.

X. Exclusion List

In addition to any other exclusions or limitations specified in this *contract, PIC* will not cover charges *incurred* for any of the following:

1. *Health care services* that *PIC* determines are not *medically necessary*.
2. *Health care services* that *PIC* determines are *investigative*, and associated expenses.
3. Charges for *health care services* determined to be duplicate services by *PIC*.
4. Personal comfort or convenience items.
5. Procedures that are *cosmetic*, or for convenience or comfort reasons, including preoperative procedures and any medical or surgical complications arising therefrom, as listed on *PIC's Cosmetic* Procedures Policy. This policy may be obtained by calling *PIC* Customer Service.
6. *Orthognathic surgery*, except when *medically necessary* for treatment of temporomandibular joint disorder and craniomandibular disorder.
7. *Health care services* received before *your* coverage under *PIC* begins or after *your* coverage under *PIC* ends.
8. *Health care services* not directly related to *your* care.
9. *Health care services* through a *provider* ordered or rendered by *providers* that are unlicensed or not certified by the appropriate state regulatory agency.
10. *Health care services* not rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate. *You* are encouraged to consult with *your provider* regarding the most cost-efficient setting or methodology appropriate for *your sickness* or *injury*.
11. Charges that exceed the *PIC non-participating provider reimbursement value* for *health care services* received from *non-participating providers*, including *non-participating provider* pharmacies, except when coverage is required for certain emergency services under Minnesota Statute 62Q.55 or certain unauthorized provider services under Minnesota Statute 62Q.556.
12. *Health care services* prohibited by law or regulation, or illegal under applicable laws.
13. Vision lenses, frames and eyeglasses, except as covered under this *contract*.
14. If *you* are over age 18, contact lenses and their related fittings, except when prescribed as *medically necessary* for the treatment of keratoconus.
15. Any *health care services* provided by a relative (i.e., a spouse, parent, brother, sister or child of the *subscriber* or of the *subscriber's* spouse) or anyone who customarily lives in the *subscriber's* household.
16. *Health care services* performed by certified surgical technicians, surgical technicians, or certified operating room technicians.
17. *Health care services* provided by massage therapists, doulas and personal trainers.
18. *Health care services* provided by *providers* who have not completed professional level education and licensure as determined by *PIC*.
19. *Health care services* for the treatment of sexual dysfunction.
20. Massage therapy.
21. Preventive medical services and supplies not ordered by a *provider*, such as but not limited to, cholesterol testing, glucose testing and mammograms, unless specifically listed in *PIC's* schedule of *Preventive Health Care Services* or provided by a *participating provider*.
22. Any charges or loss to which a contributing cause was the *member's* commission of or attempt to commit a felony or to which a contributing cause was the *member's* being engaged in an illegal occupation. This exclusion does not apply to any *sickness* or *injury* that is a result of an act of domestic violence or results from a medical condition such as alcoholism. This exclusion also does not apply to court-ordered mental health services for which coverage is required under Minnesota Statute 62Q.535.

23. Financial or legal counseling services.
24. Elective abortions, except in situations where the life of the mother would be endangered if the fetus was carried to full term.
25. Travel, transportation or living expenses.
26. Topical, oral and light-based acne treatments if *you* are age 19 and over, and associated lab and office charges.
27. Homeopathic, holistic or naturopathic medicine, including dietary supplements.
28. Drugs and medical devices that are only approved for compassionate use by the United States Food & Drug Administration.
29. *Health care services* under this plan that are paid under Medicare Part B but only to the extent: (i) *you* are eligible to be covered under Medicare Part B; (ii) *you* and/or *PIC* are not subject to Medicare secondary rules; and (iii) such an exclusion is permitted by applicable state and federal law.
30. *Health care services* including facility charges performed in a *non-participating provider* free-standing birth center unattached to a *hospital* facility.
31. Treatment of *infertility* related services.
32. Costs associated with *clinical trials* that are not *routine patient costs.*
33. *Health care services* associated with non-*covered services,* including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
34. *Health care services* and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise *medically necessary*, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for driving under the influence/driving while intoxicated, competency evaluations, and adoption studies.
35. Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care.
36. Professional services associated with substance use disorder intervention. A substance use disorder intervention is a gathering of family and/or friends to encourage *you* to seek substance use disorder treatment.
37. Sterilization, except as provided in the Preventive Contraceptive Methods and Counseling for Women section of this *contract*.
38. Sterilization reversals.
39. Cochlear implants, except for *members* under age 19 when hearing loss is not correctable by other covered procedures.
40. Nutritional and food supplements, except as covered under this *contract*.
41. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment for the treatment of behavioral health conditions.
42. Health care professional services for maternity labor and delivery in the home.
43. Health club memberships, except as covered under this *contract.*
44. Acupuncture.
45. Recreational, *educational*, or self-help therapy or items primarily *educational* in nature or for vocation, comfort, convenience or recreation. Recreation therapy is therapy provided solely for the purpose of recreation, including, but not limited to: a) physical therapy or occupational therapy to improve athletic ability, and b) braces or guards to prevent sports injuries.
46. Sexual dysfunction *prescription drugs*, unless otherwise covered in this *contract* or approved for other use by an authoritative compendia identified by the Medicare program, and/or in an article from a major peer reviewed medical journal, provided that such article uses generally acceptable scientific standards other than case reports.
47. Any weight loss programs and related services and/or drugs, except as otherwise covered as *preventive health care services.*

48. Private duty nursing, except as covered under this *contract*. This exclusion does not apply if *you* are also covered under Medical Assistance and coverage is required by Minnesota Statute 62Q.545.
49. Charges for *health care services* (a) for which a charge would not have been made in the absence of health insurance, or (b) for which *you* are not legally obligated to pay, and/or (c) from *providers* who waive any *copayment*, *coinsurance*, or *deductible* that *you* are required to pay under this *contract*, except as required under state or federal law.
50. Non-*emergency services* received outside the United States.
51. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
52. *Health care services* for gender reassignment, except when *medically necessary*.
53. Photographs, except for the condition of multiple dysplastic syndrome.
54. Coverage for costs associated with the translation of medical records and claims to English.
55. Treatment of spider veins.
56. Repair of pierced body part and surgical repair of bald spots or loss of hair.
57. Services for or related to adoption and childbirth classes.
58. Services or confinements ordered by a court or law enforcement officer that are not *medically necessary*. Services that are not considered *medically necessary* include, but are not limited to, the following: custody evaluations, parenting assessment and /or competency, education classes for Driving Under the Influence (DUI) / Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, and domestic violence programs.
59. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer the therapy. Services that do not involve direct patient contact such as delivery charges and recordkeeping.
60. Non-FDA approved use of medical marijuana, cannabis or tetrahydrocannabinol (THC).
61. Costs, charges, fees and other losses for non-*health care services*.
62. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescriptions; 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; or services that would similarly not be charged for in an onsite medical office visit; or telephone conversations, e-mails, or facsimile transmissions between licensed health care *providers*; or e-mails, or facsimile transmissions between a licensed health care *provider* and a patient.

The following exclusions are repeated from the "Description of Benefits" section":

***For ease of reference, some exclusions may contain headings for categories of *health care services*. Please note that, exclusions listed under any category of *health care services* shall apply to all *health care services*, regardless of the heading under which they are listed.**

63. Ambulance Services:
    a. See all exclusions.*
    a. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.

64. Chiropractic Services:
    a. See all exclusions.*
    b. Services to treat acute musculoskeletal conditions by manual manipulation therapy when received from a *non-participating provider.*
    c. Routine *maintenance care*.
    d. Blood, urine or hair analysis.
    e. Performance of ultrasound, MRI, EMG, waveform and nuclear medicine diagnostic studies, or other enhanced imaging.
    f. Manipulation under anesthesia.

65. Dental Services:
    a. See all exclusions.*
    b. Dental services received from a *non-participating provider*.
    c. Dental services covered under *your* dental plan.
    d. Preventive dental procedures.
    e. *Health care services* or dental services for and related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts.
    f. Orthodontia and all associated expenses.
    g. *Health care services* or dental services for or related to oral surgery and anesthesia for the removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy.
    h. *Health care services* or dental services for cracked or broken teeth that result from biting, chewing, disease or decay.
    i. Dental implants.
    j. Prescriptions written by a *dentist* unless in connection with dental procedures covered by *PIC*.
    k. *Health care services* or dental services related to periodontal disease.
    l. Occlusal adjustment or occlusal equilibration.
    m. Treatment of bruxism.
    n. Surgical extraction of impacted wisdom teeth, except as above for accidental injury to sound, natural teeth or when required for treatment of an underlying medical condition.

66. Durable Medical Equipment (DME), Services and Prosthetics:
    a. See all exclusions.*
    b. Any durable medical equipment, supplies, orthotics or prosthetics received from a *non-participating provider*.
    c. Any durable medical equipment or supplies not listed as eligible on *PIC's* durable medical equipment list, or as determined by *PIC*.
    d. Disposable supplies or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage.
    e. Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use.
    f. Replacement or repair of items when: 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen.
    g. Duplicate or similar items.
    h. Hearing aids, devices to improve hearing and related fittings or *health care services*, except as covered under this *contract*.
    i. Communication aids or devices; equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication board, or computer or electronic assisted communication.
    j. Household equipment, household fixtures and modifications to the structure of the home, escalators or elevators, ramps, swimming pools, whirlpools, hot tubs and saunas, wiring, plumbing or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
    k. Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
    l. Over-the-counter orthotics and appliances.
    m. Orthopedic shoes and custom molded foot orthotics, unless *you* have diabetes or peripheral vascular disease.
    n. Charges for sales tax, mailing and delivery.
    o. Durable medical equipment necessary for the operation of equipment determined not to be eligible for coverage.
    p. Durable medical equipment, orthotics and prosthetics necessary for activities beyond *activities of daily living*.
    q. Wigs for conditions other than alopecia areata.
    r. Upgrades to or replacement of any items that are considered *eligible charges* and covered under this section, unless the item is no longer functional and is not repairable.

67. *Emergency Services*:
    a. See all exclusions.*
    b. Non-*emergency services* received in an emergency room.

68. Home Health Services:
    a. See all exclusions.*
    b. Home health services received from a *non-participating provider*.
    c. Companion and home care services, unskilled nursing services, services provided by *your* family or a person who shares *your* legal residence.
    d. *Health care services* and other services provided as a substitute for a primary caregiver in the home.
    e. *Health care services* and other services that can be performed by a non-medical person or self-administered.
    f. Home health aides.
    g. *Health care services* and other services provided in *your* home for convenience.
    h. *Health care services* and other services provided in *your* home due to lack of transportation.
    i. *Custodial care*.
    j. *Health care services* and other services at any site other than *your* home.
    k. Recreational therapy.

69. Hospice Care:
    a. See all exclusions.*
    b. Hospice care received from a *non-participating provider*.
    c. *Health care services* and other services provided by *your* family or a person who shares *your* legal residence.
    d. Respite or rest care, except as specifically described in this section.

70. *Hospital* Services:
    a. See all exclusions.*
    b. Travel, transportation, other than ambulance transportation, or living expenses.
    c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
    d. Non-emergency ambulance service from *hospital* to *hospital*, such as transfers and admissions to *hospitals* performed only for convenience.
    e. *Health care services* to treat conditions *cosmetic* in nature, including preoperative procedures and any medical or surgical complications arising therefrom.
    f. Orthoptics and surgery for refractive conditions correctable by contacts or glasses, i.e., lasik surgery.
    g. *Health care services* for gender reassignment, except when *medically necessary*.
    h. Genetic testing and associated *health care services*, except as covered under this *contract*.
    i. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
    j. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
    k. Autopsies.
    l. *Bariatric surgeries*, including preoperative procedures, initial procedures, surgical revisions and subsequent procedures.
    m. *Health care services* or items for personal convenience, such as television rental.
    n. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
    o. Nutritional counseling, except when provided:
        1) During a *confinement*; or
        2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
        3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
        4) As counseling that is treated as a *preventive health care service*.
    p. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
    q. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
    r. Counseling, studies, *confinements, health care services* or other services ordered by a court or law enforcement officer that are not determined to be *medically necessary* by *PIC*, except as covered under this *contract*.

71. *Infertility* Services:
    a. See all exclusions.*
    b. Reversal of voluntary sterilization.
    c. Adoption costs.
    d. Gamete intrafallopian transfer (GIFT) procedures.
    e. Zygote intrafallopian transfer (ZIFT) procedures.
    f. Intracytoplasmic sperm injection (ICSI).
    g. In-vitro fertilization.
    h. *Health care services* related to surrogate pregnancy for a person who is not a *member* under this *contract*.
    i. Artificially assisted technology, such as, but not limited to, artificial insemination (AI) and intrauterine insemination (IUI).
    j. Sperm, ova or embryo acquisition, retrieval or storage.
    k. Drugs for the treatment of *infertility*.
    l. Treatment of male and female *infertility* and associated *health care services*.

72. Office Visits:
    a. See all exclusions.*
    b. Health education, except when:
        1) Provided during an office visit for non-*preventive health care services*; or
        2) It is counseling that is treated as a *preventive health care service*.
    c. Any weight loss programs and related *health care services*, except as otherwise covered as *preventive health care services*.
    d. Nutritional counseling, except when provided:
        1) During a *confinement*; or
        2) As outpatient self-management training and education for the diagnosis and treatment of diabetes by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association; or
        3) In a *physician's* office, clinic system or *hospital* setting to a *member* who has been diagnosed by a *physician* with a chronic medical condition; or
        4) As counseling that is treated as a *preventive health care service*.
    e. Marital counseling, relationship counseling, family counseling except as covered under this *contract*, or other similar counseling or training services.
    f. Professional sign language and foreign language interpreter services in a *provider's* office.
    g. Exams, other evaluations and/or services for employment, insurance, licensure, judicial or administrative proceedings or research, except as otherwise covered under this section or treated as a *preventive health care service*.
    h. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *PIC*.
    i. Genetic testing and associated *health care services*, except as covered under this *contract*.
    j. Hypnosis and chelation therapy, except chelation therapy will be covered when *medically necessary* for the treatment of heavy metal poisoning.
    k. Routine foot care, unless required due to blindness, diabetes or peripheral vascular disease.
    l. Treatment of cleft lip and cleft palate, except for such treatment of a covered dependent child if treatment is scheduled or started prior to the covered dependent child reaching age 19.
    m. Vision therapy/Orthoptics.
    n. *Health care services* provided by an audiologist that are not provided in an office setting.
    o. Counseling, studies, or services ordered by a court or law enforcement officer that are not determined to be *medically necessary*, except as covered under this *contract.*
    p. Nutritional and food supplements, except as covered under this *contract*.

73. Organ and Bone Marrow *Transplant Services*:
    a. See all exclusions.*
    b. *Transplant services* received from a *provider* that is not a *designated transplant network provider.*
    c. *Health care services* related to organ, tissue and bone marrow transplants and stem cell support procedures or peripheral stem cell support procedures that are *investigative* for *your* diagnosis or condition.
    d. *Health care services*, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved as *medically necessary* by *PIC*.
    e. *Health care services*, chemotherapy, radiation therapy or any therapy that damages the bone marrow, except in cases involving a bone marrow or stem cell transplant.

f. Non-*emergency* ambulance service from *hospital* to *hospital* such as transfers and admission to *hospitals* performed only for convenience.
g. Treatment of medical complications to a donor after procurement of a transplanted organ.
h. Computer search for donors.
i. Private collection and storage of blood and umbilical cord/umbilical cord blood, unless related to scheduled future *covered services.*
j. Travel expenses related to a covered transplant.
k. *Health care services* for or in connection with fetal tissue transplantation, except for non-*investigative* stem cell transplants.
l. Organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, excluding surgical implantation of US Food and Drug Administration (FDA) approved ventricular assist devices.

74. Physical Therapy, Occupational Therapy and Speech Therapy:
a. See all exclusions.*
b. Physical therapy, occupational therapy and speech therapy received from *a non-participating provider*.
c. *Custodial care* or *maintenance care*.
d. Therapy provided in *your* home for convenience.
e. Therapy for conditions that are self-correcting.
f. Voice training and voice therapy absent a medical condition.
g. *Investigative* therapies.
h. Group therapy for physical therapy, occupational therapy and speech therapy.
i. *Investigative* therapies for the treatment of autism, such as secretin infusion therapies.
j. Sensory integration therapy when used for a reason other than the treatment of feeding disorders.
k. *Health care services* for homeopathy and immunoaugmentive therapy.

75. *Prescription Drug* Services:
a. See all exclusions.*
b. *Prescription drugs* obtained from a pharmacy that is a *non-participating provider.*
c. Replacement of a *prescription drug* due to loss, damage, or theft.
d. Drugs available over-the-counter (OTC) , except prescribed OTC drugs that are required to be covered as *preventive health care services* under the *Affordable Care Act* as covered under the "Preventive Contraceptive Methods and Counseling for Women" or "*Preventive Health Care Services*" sections of this *contract.*
e. *Prescription drugs* equivalent to or similar to OTC drugs, except as covered under this *contract.*
f. OTC home testing products, except as covered under this *contract.*
g. Drugs not approved by the FDA and drugs not approved by the FDA for a particular use, except off-label drugs used for the treatment of cancer or when *PIC*, at its sole discretion, determines to include the drug on its *formulary* or approves coverage of the drug for the particular use.
h. Take home drugs when dispensed by a *physician.*
i. Weight loss drugs.
j. Prescriptions written by a *dentist* unless in connection with dental procedures covered under this *contract.*
k. Drugs used for *cosmetic* purposes.
l. Unit dose packaging.
m. *Prescription drugs* for the treatment of *infertility*.
n. Non-FDA approved route of administration (e.g. drug that is FDA approved for oral use, but is being applied topically).
o. *Prescription drugs* given or administered as part of a drug manufacturer's study.
p. *Prescription drugs* if purchased by mail order through a program not administered by *PIC's* pharmacy vendor.
q. *Prescription drugs* for the treatment of sexual dysfunction.
r. Off-label use of drugs, determined to be *investigative*.
s. Certain *combination drugs* and other drugs, regardless of *formulary* status will not be covered according to *PIC*'s pharmacy policy titled Cost Benefit Program. Contact *PIC* Customer Service for a copy of this policy or a list of the affected drugs. This policy is subject to change.
t. *Compounded drugs* that are being used for bio-identical hormone replacement therapy, except as otherwise covered under this *contract.*
u. Oral, injectable and insertable contraceptives and contraceptive devices, except when covered for a medical condition or as a *preventive health care service* in the "Preventive Contraceptive Methods and Counseling for Women" section of this *contract.*
v. Prescribed or non-prescribed vitamins or minerals, including over-the-counter, unless covered as *preventive health care services.*

w. *Specialty drugs* obtained at any pharmacy other than Fairview Specialty Pharmacy or other designated specialty pharmacy, except limited distribution *specialty drugs* only available through the manufacturer's select specialty pharmacy and not available through Fairview Specialty Pharmacy.
x. *Compounded drugs* obtained from any pharmacy other than Fairview Compounding Pharmacy or another designated compounding pharmacy.
y. Non-*formulary* drugs, unless an exception is obtained from *PIC.*
z. Any portion of a charge for a *prescription drug* which *you* are not required to pay or for which *you* receive reimbursement due to use of a manufacturer's coupon, rebate or other program that alters the amount *you* are legally obligated to pay, and/or waives any *coinsurance* or *deductible* that *you* are required to pay under this *contract,* except as required under state or federal law.

76. Preventive Contraceptive Methods and Counseling for Women:
    a. See all exclusions.*
    b. Contraceptives and related *health care services* received from *non-participating providers*, except *member* education and counseling about contraceptive methods.
    c. Sterilization procedures performed by *non-participating providers.*
    d. Abortions are not covered under this section of this *contract.*
    e. Non-prescribed over-the-counter contraceptives, including condoms, spermicides, and emergency contraceptives.
    f. Hysterectomies are not covered under this section of this *contract*.
    g. Anesthesia and facility services related to sterilization procedures that are performed during other surgical procedures, such as but not limited to Cesarean section birth, gall bladder removal, and abdominal hernia repair, are not covered under this section of this *contract*.
    h. Reversal of sterilization procedures.
    i. Non-*preventive health care services* are not covered under this section of this *contract.*

77. *Preventive Health Care Services*:
    a. See all exclusions.*
    b. *Preventive health care services* received from a *non-participating provider*.
    c. Any *health care services* performed during or in conjunction with an annual or periodic wellness exam that exceeds the services described in the *Preventive Health Care Services* section of this *contract*.
    d. Routine eye examinations, except as otherwise covered under this *contract*
    e. Electronic cigarettes, e-cigarettes, personal vaporizers, and similar forms of nicotine delivery systems.
    f. Tobacco cessation intervention programs and related *health care services*, except as otherwise covered under this *contract.*
    g. Non-*preventive health care services* are not covered under this section of this *contract.*
    h. Non-routine *health care services*, including but not limited to non-routine prenatal services, are not covered under the "*Preventive Health Care Services*" section of this *contract*.
    i. Non-prescribed over-the-counter medications.

78. *Reconstructive* Surgery:
    a. See all exclusions.*
    b. *Health care services* to treat conditions that are *cosmetic* in nature.

79. *Skilled Nursing Facility* Care:
    a. See all exclusions.*
    b. Skilled nursing facility care received from a *non-participating provider*.
    c. Private room, except when *medically necessary* or if it is the only option available at the admitted facility.
    d. Respite or *custodial care*.

80. Specified *Non-Participating Provider* Services:
    a. See all exclusions.*

81. Vision Care – Pediatric:
    a. See all exclusions.*
    b. Vision care received from a *non-participating provider*.
    c. Vision care received after the end of the month in which the *member* reaches age 19.
    d. Lenses, frames or optical devices not *medically necessary*.
    e. *Health care services* or materials not meeting the standards of accepted optometric practices.
    f. Repairs to frames and lenses.
    g. Vision therapy.
    h. Frames that are brand name or mid to high-end fashion frames.

i. Replacement of stolen or lost eyewear.
j. Non-prescription lenses, including reading glasses without a prescription.
k. Two pairs of eyeglasses in lieu of bifocals.
l. Elective lenses, including, but not limited to, toric, gas permeable and bifocal contact lenses.
m. Insurance of contact lenses
n. Saline or other solutions for the care of contact lenses.
o. Prosthetic devices and associated *health care services.*
p. Sunglasses.
q. Sport lenses and sport frames.
r. Special lens designs or coatings not *medically necessary*, including but not limited to special lenses or lens modifications that are not to correct visual acuity problems, tinted lenses, transition lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
s. Replacement of lenses or frames due to provider error in prescribing, frame selection or measurement. The provider making the error is responsible for bearing the cost of correcting the error.

XI. Ending *Your* Coverage

Your coverage under this *contract* will end on the earliest of the following dates:

1. The date *PIC* discontinues or does not renew this *contract* as provided herein.
2. The end of the month in which *PIC* receives *your* written request to cancel coverage.
3. The end of the month in which it is determined that *you* were never eligible for coverage under this *contract* or in which *you* ceased to be eligible for coverage under this *contract*.
4. The end of the month in which the *subscriber's* covered spouse or covered *dependent* is no longer eligible as a covered spouse or covered *dependent*.
5. In accordance with the terms of the applicable grace period, if *premium* has not been paid.
6. The date *you* (or someone acting on *your* behalf) performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of this *contract*, according to the notice *PIC* provides when it rescinds or terminates this *contract.*
7. The end of the month following the date *you* enter active military duty of more than 31 calendar days. Upon completion of active military duty, *your* coverage will be reinstated, provided *you* notify *PIC* within 90 calendar days after the end of *your* active duty.
8. The end of the month or such later date, as determined by *PIC*, after the *subscriber* moves outside the state of Minnesota.

XII. Portability of Coverage

If a *dependent* loses coverage under this *contract* due to death of the *subscriber,* loss of eligibility under the *contract* as a *dependent* including *subscriber's* enrollment in Medicare or divorce in the case of a spouse or a *dependent, PIC* will allow the covered *dependents* of the *subscriber* to remain covered under this *contract* as long as a covered spouse becomes the *subscriber* to the *contract* or, if there is no covered spouse, each dependent child may transfer as a *subscriber* to another substantially similar *contract* offered by *PIC. Dependents* under age 18 may become *subscribers* only if they receive parental or guardian consent. *PIC* will permit the transfer (if election is made within 31 calendar days of the date of loss of coverage) without any limitation or other restriction of any type other than those which applied to the *subscriber* under the prior contract.

If *you* transfer to a substantially similar contract offered by *PIC*, any amounts that *you* already paid under this *contract* for *covered services* that are subject to *coinsurance, deductibles* and *out of pocket limits*, or that *you* received that are subject to benefit limits or visit maximums, and any *covered services* that *you* received that are subject to benefit limits or visit maximums under this *contract*, will continue to count toward any applicable *deductibles, out of pocket limits*, benefit limits and/or visit maximums.

XIII. Subrogation and Reimbursement

PIC's Subrogation Rights

For the purposes of this section, "subrogation" means *PIC*'s right to allocate risk in accordance with Minn. Stat. §§ 62A.095 and 62A.096 so that *your* medical claims are ultimately paid by the party that should rightfully bear the burden of the loss.

1. *PIC* is subrogated to any and all claims and causes of action that might arise against any person, corporation, and/or other entity and any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, liability insurance policies, homeowners liability insurance coverage, medical malpractice insurance coverage, patient compensation fund, and any applicable umbrella insurance coverage or other insurance or funds; and
2. *PIC*'s subrogation interest is the reasonable cash value of any benefits received by *you*. *PIC*'s subrogation interest applies only after *you* have received a full recovery for *your sickness* or *injury* from another source of compensation for *your sickness* or *injury;* and
3. *PIC*'s right to recover its subrogation interest is subject to a pro rata subtraction for actual monies paid for costs and reasonable attorney fees *you* pay in obtaining *your* recovery unless *PIC* is separately represented by an attorney; and
4. If *PIC* is separately represented by an attorney, the attorney representing *PIC* and the attorney representing the covered person may enter into an agreement regarding allocation of costs and reasonable attorney fees. If *PIC* and the covered person cannot reach agreement on allocation, *PIC* and the covered person shall submit the matter to binding arbitration; and
5. Nothing in this section shall limit *PIC*'s right to recovery from another source which might otherwise exist at law.

Notice Requirement

You must provide timely written notice to *PIC* of the pending claim, if *you* make a claim against a third party for damages that include repayment for medical and medically related expenses *incurred* for *your* benefit. Notwithstanding any other law to the contrary, the statute of limitations applicable to *PIC's* rights for reimbursement or subrogation does not commence to run until the notice has been given.

XIV. Coordination of Benefits

As a *member*, *you* agree to permit *PIC* to coordinate *PIC's* obligations under this *contract w*ith payments under any other health benefit plans as specified below, which cover *you* as a *subscriber* or *dependent*. *You* also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. *You* agree to authorize *PIC's* billing to other health plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of *you* or *your* representative, *you* must provide any facts needed to pay the claim. If the information cannot be disclosed without consent, *PIC* will not pay benefits until the information is given.

Application. This Coordination of Benefits provision applies when *you* have health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan might cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions. These definitions only apply to the Coordination of Benefits provision.

Allowable Expenses. Means health care services or expenses, including copayments, deductibles and coinsurance that are covered at least in part by any of the plans covering *you*. When a plan provides benefits in the form of services (for example a staff model HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period. Means a *calendar year*. However, it does not include any part of a year during which *you* have no coverage under this *contract*, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan. Means a plan that provides health benefits to persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan and that limits or excludes benefits or services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. Means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Plan. Means any of the following that provides benefits or services for medical or dental care or treatment.

1. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured).
2. Hospital indemnity benefits in excess of $200 per day.
3. Medical care components of group long-term care policies, such as skilled nursing care.
4. A labor-management trusteed plan or a union welfare plan.
5. An employer or multi-employer plan or employee benefit plan.
6. Medicare or other governmental benefits, as permitted by law.
7. Insurance required or provided by statute.
8. Medical benefits under group or individual automobile policies.
9. Individual or family insurance for hospital or medical treatment or expenses.
10. Closed panel or other individual coverage for hospital or medical treatment or expenses.

Plan does not include any:

1. Amounts of hospital indemnity insurance of $200 or less per day.
2. Benefits for non-medical components of group long-term care policies.
3. School accident type coverages.
4. Medicare supplement policies.
5. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan. Means the order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan," when compared to the other plan covering *you*.

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

Order of Benefit Determination Rules. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This plan determines its order of benefits by using the first of the following that applies:

1. **Nondependent/Dependent:** The plan that covers the person other than as a dependent, for example as an employee, *subscriber*, or retiree, is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:
   a. secondary to the plan covering the person as a *dependent*; and
   b. primary to the plan covering the person as a nondependent (e.g., a retired employee);
   then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. **Child Covered Under More Than One Plan:** The order of benefits when a child is covered by more than one plan is:

   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the non-custodial parent; and then
      - The plan of the spouse of the non-custodial parent.

   d. For a child covered under more than one plan by persons who are not the parents of such child, the order of benefits shall be determined under paragraph 2.a. of this section as if those persons were parents of such child.

   e. For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 of this section applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.a of this section to the dependent child's parent(s) and the dependent child's spouse.

3. **Active/Inactive Employee:** The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example, coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. **Continuation Coverage:** If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
   a. The plan covering the person as an employee, *member*, *subscriber*, or retiree (or as a *dependent* of an employee, *member, subscriber*, or retiree) is the primary plan; and
   b. The continuation coverage is the secondary plan.

   If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.

5. **Longer/Shorter Length of Coverage.** The plan that covered *you* as an employee, *member, subscriber* or retiree longer is primary.

   Note: Under this *contract, PIC* will not pay more than it would pay as the primary plan.

The Effect of the Benefits of this Plan*:* When this plan is secondary, it may reduce its benefits at the time of processing, so that the total benefits paid or provided by all plans for each claim are not more than 100% of total allowable expenses for such claim. The reduction in this plan's benefits is equal to the difference between:

1. The benefit payments that this plan would have paid had it been the primary plan; and

2. The benefit payments that this plan actually paid or provided.

When the benefits of this plan are reduced as described above, each *benefit* is reduced in proportion to any applicable limit, such as the *deductible* of this plan.

Right to Receive and Release Information. Certain facts about health care coverage and services are needed to apply Coordination of Benefit rules and to determine benefits payable under this plan and other plans. *PIC* may get the facts from or give them to any other organization or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. *PIC* need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give *PIC* any facts it needs to apply those rules and determine benefits payable. Release of information will comply with state and federal laws.

Facility of Payment. A payment made under another plan may have included an amount that should have been paid under this plan. If it does, *PIC* may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. *PIC* will not pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by *PIC* is more than it should have paid, *PIC* may recover the excess from one or more of the following:

1. The persons *PIC* has paid or for whom it has paid; or

2. Any other person or organization that may be responsible for the benefits or services provided to *you*.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordinating With Medicare: This section describes the method of payment if Medicare pays as the primary plan.

If a *provider* has accepted assignment of Medicare, *PIC* determines allowable expenses based upon the amount allowed by Medicare. *PIC's* allowable expenses are the lesser of (1) the *fee schedule* amount, the *PIC non-participating provider reimbursement value*, as applicable, or (2) the Medicare allowable amount. *PIC* pays the difference between what Medicare pays and *PIC's* allowable expenses.

When Medicare would be the primary plan, but *you* are eligible for Medicare and have not enrolled with Medicare, then *PIC* will pay as the primary plan.

Renal Failure. If *you* begin to have services related to renal failure, *we* request that *you* sign up for Medicare.

XV. How to Submit a Claim if *You* Receive a Bill for *Covered Services* from a *Provider*

Claim Forms. If *you* submit a notice of claim to *PIC* without adequate written proof of loss, *PIC* will furnish *you* a claim form for filing *your* proof of loss. If *you* are not furnished a claim form within 15 calendar days after *you* provided notice of a claim to *PIC*, *you* should submit written proof which documents the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges for which the claim is made.

Timely Payment of Claims. *Post-service claims* for benefits will be paid promptly upon receipt of an itemized bill and written proof of loss. Benefits that are payable periodically during a period of continuing loss will be paid monthly. All or any portion of any benefits provided by *PIC* may be paid directly to the *provider* rendering the services. Payment will be made according to *PIC* coverage guidelines.

Payment of Claims. All or any portion of any benefits provided to *you* or on *your* behalf for *hospital*, nursing, medical or surgical services may, at *our* option, be paid directly to the *hospital* or *provider* providing such services.

At *our* option, all payments for claims may be made directly to the *provider* of medical services, the custodial parent or Minnesota Department of Human Services rather than to the *subscriber*, for claims *incurred* by a child who is covered as a *dependent* of a *subscriber* who has legal responsibility for the *dependent's* medical care pursuant to a court order, provided *we* are informed of such order. This payment will discharge *us* from all further liability to the extent of the payment made. If the *member* who receives such services is deceased at the time of payment, *PIC* may at its option pay the *provider* of medical services or the *member's* estate.

Bills from *Participating Providers*

When *you* present *your* identification card at the time of requesting services from *participating providers*, paperwork and submission of *post-service claims* relating to services will be handled for *you* by *your participating provider*. *You* may be asked by *your provider* to sign a form allowing *your provider* to submit claims on *your* behalf. If *you* receive an invoice or bill from *your provider* for services, simply return the bill or invoice to *your provider*, noting *your* enrollment with *PIC*. *Your provider* will then submit the *post-service claim* to *PIC* in accordance with the terms of its participation agreement. *Your post-service claim* will be processed for payment according to *PIC* guidelines. *PIC* must receive *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. *Post-service claims* received after the deadline will be denied.

Notice of Claim. If *you* receive a bill from *your provider* for services and *you* are directly submitting notice of *your* claim to *PIC*, *we* encourage *you* to submit written notice of *your* claim to *PIC* within 20 calendar days after the date the service was *incurred* or as soon as reasonably possibly. This notice should be sent to *PIC* at 6105 Golden Hills Drive, Golden Valley, Minnesota 55416.

Proof of Loss and Claim Submission. If *you* are directly submitting an itemized bill and written proof of loss to *PIC*, *we* encourage *you* to submit *your* itemized bill and written proof of loss within 90 calendar days after the date the service was *incurred* or as soon as reasonably possible. In all cases *PIC* must receive these *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges. *Post-service claims* received after the deadline will be denied.

Bills from *Non-Participating Providers*

Notice of Claim. *We* encourage *you* to submit written notice of *your* claim to *PIC* within 20 calendar days after the date the service was *incurred* or as soon as reasonably possibly. This notice should be sent to *PIC* at 6105 Golden Hills Drive, Golden Valley, Minnesota 55416.

Proof of Loss and Claim Submission. *We* encourage *you* to submit *your* itemized bill and written proof of loss within 90 calendar days after the date the service was *incurred* or as soon as reasonably possible. In all cases *PIC* must receive these *post-service claims* within 12 months after the date services were *incurred*, except in the absence of *your* legal capacity. The itemized bill and written proof of loss must document the date of service, the type of service, a specific medical diagnosis and treatment, service or procedure code, *provider* name and itemized charges. *Post-service claims* received after the deadline will be denied.

XVI. Initial Benefit Determinations of *Post-Service Claims*

Post-service claims are claims that are filed for payment of benefits by *PIC* after medical care has been received and are submitted in accordance with *PIC's post-service claim* filing procedures.

If *your* attending *provider* submits a *post-service claim* on *your* behalf, the *provider* will be treated as *your* authorized representative by *PIC* for purposes of such claim and associated appeals unless *you* specifically direct otherwise to *PIC* within ten business days from *PIC's* notification that an attending *provider* was acting as *your* authorized representative. *Your* direction will apply to any remaining appeals.

If *your post-service claim* is denied, *PIC* will communicate such denial within 30 calendar days after receipt of a *post-service claim* submitted in accordance with this *contract's* filing procedures, provided *PIC* has all necessary information it needs to make an initial benefit determination. Even if *PIC* has all information it needs to make an initial benefit determination, but determines that an extension is necessary due to matters beyond its control, or the control of any associated group health plan, because it is subject to the requirements of the claims procedures under the US Department of Labor rules at 29 CFR § 2560.503-1 et seq., in accordance with the *Affordable Care Act*, then *PIC* may extend the time period for its initial benefit determination by sending written notice to *you* before the end of the initial 30-calendar day benefit determination period, which describes the circumstances that require the extension. *PIC* will notify *you* of its initial determination within 15 calendar days after the end of the initial 30-calendar day benefit determination period.

If *PIC* does not have all necessary information it needs to make an initial benefit determination, then *PIC* may extend the time period for making the initial benefit determination by sending written notice to *you* before the end of the initial 30-calendar day determination period, which describes the missing information and provides a grace period to *you* for providing the necessary information of at least 45 calendar days from the date *you* receive the notice. *PIC* will notify *you* of its initial benefit determination within 15 calendar days after the earlier of 1) the date on which *PIC* receives the requested information and 2) the end of the specified grace period, if *PIC* does not receive the requested information. If *you* do not provide the requested information within the time period specified, *your* claim will be denied. If, however, *you* or *your* authorized representative submit the requested information after the specified grace period ends and within 365 calendar days after the date *you incurred* services (except in the absence of *your* legal capacity), *PIC* may, but is not required to, reconsider the submitted information; and will not consider information it receives more than 365 calendar days after the date *your* services were *incurred*.

If *your post-service claim* is denied, notification will be provided to *you*. This notice will explain:

- Information sufficient to identify the claim involved and any information required by law;
- The reason for the denial;
- The part of this *contract* on which it is based;
- Any additional material or information needed to make the claim acceptable and the reason it is necessary; and
- The procedure for filing a complaint.

XVII. Complaints

Complaints About Administrative Operations and Matters

You may submit a complaint to *PIC* either by telephone or in writing within 180 calendar days following the incident or event that was the basis for *your* complaint. If *your* telephone complaint is not resolved to *your* satisfaction within ten calendar days after *PIC* receives *your* complaint, *you* may submit *your* complaint in writing. *Your* written complaint should include the specific reason for the complaint and provide any supporting documents. Customer Service is available to provide any assistance necessary to complete a written complaint form.

PIC will notify *you* that it received *your* written complaint within 14 calendar days, unless *your* complaint already is resolved. *PIC* will notify *you* of its decision within 30 calendar days from the date that it receives *your* complaint.

In certain circumstances, *PIC* may take up to 14 additional calendar days to notify *you* of its decision. In such cases, *PIC* will notify *you*, in advance, of the reasons for the extension and the date *you* may expect the final decision.

Complaints About Claims

If *you* are requesting benefits that require pre-certification (a *pre-service claim*) or are currently receiving services and are requesting an extension of these services (concurrent care claim), *your* request will be handled in accordance with the pre-certification section of this *contract*. If *your* complaint is about a claim for benefits for services received (a *post-service claim*), *your* complaint must be submitted to *PIC* within 180 calendar days following the initial denial determination.

PIC will notify *you* of its decision on *your post-service claim* complaint within 30 calendar days from the date that it receives *your* complaint. This time period may be extended for up to an additional 14 calendar days if *you* agree.

XVIII. Internal Appeals Process

During any appeal as described below, *your* coverage will remain in force. *PIC* must be provided all the information needed to make a decision. If *PIC* does not have all information it needs and cannot obtain complete information from *you* or *your provider* within the time periods set forth below for deciding an appeal, *your* appeal will be denied.

1. **Acute Care Services Appeals.** If *your* request for pre-certification of acute care services is wholly or partially denied and *you* have not received such services or if *you* are currently receiving acute care services and a request for the extension of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to *PIC* in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. *You* have the right to present written evidence and telephonic testimony as part of the appeals process.

   When *you* appeal the initial determination for medical reasons, *PIC* will arrange for review of the clinical material by a *physician* in the same or similar specialty who did not make the initial determination. As quickly as *your* medical condition requires, but no later than 72 hours of *PIC*'s receipt of *your* appeal, *you, your attending health care professional* and *your* attending *provider* will receive telephone notice of *PIC*'s decision, including the specific reasons for it and the procedure for requesting an external review to the extent external review is required by law. This time period may be extended if *you* agree. Written notification will be sent to *you, your attending health care professional* and *your* attending *provider* within one business day of the determination, or sooner if *your* medical condition requires.

2. **Non-Acute Care Services Appeals.** If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services or if *you* are currently receiving non-acute care services and a request for the extension of these services is wholly or partially denied, *you* or *your* authorized representative may submit an appeal of that denial within 180 calendar days after receiving notice that *your* request was denied. *Your* appeal can be submitted to *PIC* in writing, by telephone, or electronically, along with any issues, comments, and additional information, as appropriate. *You* have the right to present written evidence and telephonic testimony as part of the appeals process.

   When *you* appeal the initial determination for medical reasons, *PIC* will arrange for review of the clinical material by a *physician* in the same or similar specialty who did not make the initial determination. Within 30 calendar days after *your* appeal is received by *PIC, you, your attending health care professional* and *your* attending *provider* will receive written notice of *PIC's* decision, including the specific reasons for it and the procedure for requesting an external review to the extent external review is required by law. This time period may be extended for up to an additional 14 calendar days if *you* agree.

3. **Concurrent Care Services Appeals.** If *your* request for certification extension (concurrent care) is wholly or partially denied, *you* or *your* authorized representative may submit an appeal to *PIC* on the same basis as described above. Acute

concurrent care services appeals submitted to *PIC* will be reviewed the same as acute care services appeals above. Non-acute concurrent care services appeals submitted to *PIC* will be reviewed the same as non-acute care services appeals above.

4. **Complaint Appeals.** If *your* complaint regarding an administrative operation or matter or a *post-service claim* is not resolved to *your* satisfaction, then within 60 calendar days after receiving notice that *your* complaint was wholly or partially denied, *you* or *your* authorized representative may request an appeal. *Your* appeal can be submitted to *PIC* in writing, along with any issues, comments, and additional information as appropriate. *You* have the right to present written evidence and telephonic testimony as part of the appeals process for any appeal that involves a medical determination in its resolution, but only with respect to the resolution of the medical determination aspect.

   Within 30 calendar days after any written appeal requiring a medical determination in its resolution is received by *PIC*, *you* will receive written notice of *PIC's* decision, including the specific reasons for it and the procedure for requesting an external review to the extent external review is required by law. Within 30 calendar days after any other written appeal is received by *PIC*, *you* will receive written notice of *PIC's* decision, including the specific reasons for it. These time periods may be extended for up to an additional 14 calendar days if *you* agree.

5. **Access to Relevant Documents.** Upon request and free of charge, *you* have the right to review, reasonable access to, and receive copies of all documents, records, and other information relied upon or otherwise relevant to *your* appeal. If *PIC* generates, relies upon, or considers any new or additional evidence in connection with an appeal, or identifies any new or additional rationale for a denial in connection with an appeal, it will be provided to *you* so that *you* have a reasonable opportunity to respond.

XIX. External Review Process

An external review organization is an independent entity under contract with the State of Minnesota to review health plan appeals. If *you* or someone acting on *your* behalf has exhausted, or are deemed under applicable law to have exhausted, *PIC*'s internal appeals processes as described in the "Internal Appeals Process" section of this *contract*, *you* or *your* authorized representative may file a request for external review, along with *your* filing fee of $25, as noted below, with the Minnesota Department of Commerce at the address below:

External Review Process
Minnesota Department of Commerce
85 East Seventh Place
Suite 280
St. Paul, MN 55101-2198

You are deemed to have exhausted *PIC*'s internal appeals process, if *PIC* waives the exhaustion requirement, *PIC* fails to substantially comply with the requirements of this section or *you* request an expedited external review at the same time *you* qualify for and request an acute care service appeal.

If *you* want an external review, y*ou* must request it within six months after the date of *PIC*'s denial determination.

Cases involving fraudulent marketing and agent misrepresentation are not eligible for external review. External review decisions are binding on *PIC*, but are not binding on *you.* The fee for an external review is $25 and the maximum fee *you* may be charged in one year for external reviews is $75. This fee may be waived due to hardship and will be refunded by the Minnesota Department of Commerce, its contracted external review organization, or its designee if *you* prevail and *PIC's* denial decision is completely reversed.

How to File a Complaint with the Department of Commerce

You or someone acting on *your* behalf may file a complaint with the Commissioner of Commerce at any time. *You* may reach the Minnesota Department of Commerce at 651.539.1600 within the Twin Cities metropolitan area or by calling 1.800.657.3602 from outside the Twin Cities.

XX. Definitions

Activities of Daily Living — *Eating*, *toileting*, *transferring*, *bathing*, *dressing*, walking, and *continence*.

Acute Care Facility — A facility that provides care to *you* when *you* are in the acute phase of a *sickness* or *injury* and will probably have a stay of less than 30 calendar days.

Affordable Care Act — The federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance and regulations issued under these acts.

Attending Health Care Professional — The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to *you*. *Attending health care professional* shall include only *physicians*; chiropractors; *dentists*; mental health professionals; podiatrists; and advanced practice nurses.

Bariatric Surgery — Surgery and related expenses for the treatment of obesity.

Bathing — Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Biofeedback — The technique of making unconscious or involuntary bodily processes (such as heartbeat or brain waves) perceptible to the senses in order to manipulate them by conscious mental control.

Calendar Year — The 12-month period beginning January 1 and ending the following December 31.

Clinical Trial — A phase I, phase II, phase III, or phase IV *clinical trial* that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The *clinical trial* must meet one of the following:

1. Federally-funded *clinical trial* in which the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. National Institutes of Health.
   b. Centers for Disease Control and Prevention.
   c. Agency for Health Care Research and Quality.
   d. Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in paragraphs a. through d. above or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. If the clinical study or investigation is conducted by the Department of Veterans Affairs, Department of Defense, or the Department of Energy, has been reviewed and approved through a system of peer review that the Secretary of the Department of Health and Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and there has been an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. A study or investigation conducted under an investigational new drug application reviewed by the FDA.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Coinsurance	A portion of *eligible charges* that is paid by *you* and a separate portion that is paid by *PIC* for *covered services* and supplies. *Your coinsurance* is a percentage of those *eligible charges* that are the 1) discounted charges that are negotiated with the *participating provider* and calculated at the time the *claim* is processed; or 2) *PIC non-participating provider reimbursement value*. In some cases, after a *claim* is processed, further amounts may be paid or returned, such as for *risk allowances and risk sharing*. *Your coinsurance* calculations will not be changed by such subsequent adjustments.
Combination Drugs	A *prescription drug* in which two or more chemical entities are combined into one commercially available dosage form.
Compounded Drugs	Customized medications prepared by a pharmacist from scratch using raw chemicals, powders and devices according to a *physician's* specifications to meet *your* needs.
Confinement	An uninterrupted stay of 24 hours or more in a *hospital, skilled nursing facility*, rehabilitation facility, or licensed residential treatment facility.
Continence	Ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.
Contract	The legal agreement between the *subscriber* and *PIC* relating to the provision of *health care services*, which consists of this document and any amendments.
Convenience Care Center	A health care clinic whose primary purpose is to provide immediate treatment for the diagnosis of minor conditions.
Copayment	The fixed amount of *eligible charges* you must pay to the *provider* for covered *health care services* received. The *copayment* may not exceed the charge billed for the covered *health care services*.
Cosmetic	Services and procedures that improve physical appearance but do not correct or improve a physiological function, and are not *medically necessary*.
Covered Services	Services or supplies that are provided by *your* licensed *provider* or clinic and covered by *PIC*, subject to all of the terms, conditions, limitations and exclusions of *PIC*.
Custodial Care	Services to assist in *activities of daily living* and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, *bathing*, and *eating*.
Day Treatment Services	Any professional or *health care services* at a *hospital* or licensed treatment facility for the treatment of mental and substance use disorders.
Deductible	The amount of *eligible charges* that *you* must *incur* and pay in a *calendar year* before *PIC* will pay benefits.
Dental Specialist	A *dentist* board eligible or certified in the areas of endodontics, oral surgery, orthodontics, pedodontics, periodontics, and prosthodontics.
Dentist	A licensed doctor of dental surgery or dental medicine, lawfully performing dental services in accordance with governmental licensing privileges and limitations.
Dependent(s)	The *subscriber's* spouse or children as described in the "Eligibility, Enrollment, and *Effective Date*" section.
Designated Transplant Network Provider	Any licensed *hospital*, health care *provider*, group or association of health care *providers* that satisfies the quality, outcome, and accessibility needs of *PIC* and its *members*, and has contracted to participate as a designated transplant provider in the specific *PIC participating provider* network designated by *PIC* to provide benefits for organ or bone marrow transplant or stem cell support and all related services and aftercare for *you*.
Dressing	Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

Eating — Feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.

Educational — A service or supply: (1) that is primarily intended to provide training in the *activities of daily living*, instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or (2) that is provided to promote development beyond any level of function previously demonstrated, except in the case of a child with congenital, developmental, or medical conditions that have significantly delayed speech or motor development as long as progress is being made towards functional goals set by the attending *physician*.

Effective Date — The date *you* become eligible for health care benefits under this *contract* and complete all enrollment requirements.

Eligible Charges — A charge for *health care services*, subject to all of the terms, conditions, limitations and exclusions of *PIC* and for which *PIC* or *you* will pay.

Eligible Individual — An individual whom *PIC* determines has met the eligibility requirements for enrolling in this *contract*, which requirements include, but are not limited to, residency in a Minnesota service area served by this *contract.* Such residency requirement does not apply to *dependents*.

Emergency — The onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

1. Placing *your* health (or, if *you* are a pregnant individual, the health of *you* or *your* unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services — A medical screening examination that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate such *emergency* medical condition and such further medical examination and treatment required to stabilize the patient.

Essential Health Benefits — The categories of *covered services* this *contract* is required to cover under the *Affordable Care Act*.

Fee-for-Service — Method of payment for *provider* services based on each visit or service rendered.

Fee Schedule — The amount that the *participating provider* has contractually agreed to accept as reimbursement in full for *covered services* and supplies. This contracted amount may be less than the *provider's* usual charge for the service.

If *health care services* are delivered to *you* via telemedicine by a distant site *participating provider* who is **not** a designated *participating provider* for *web based (online) care*, *PIC* will reimburse such *participating provider* on the same basis and using the same *fee schedule* as would apply if the *covered services* had been delivered in person by the distant site *participating provider*.

Formulary — A list, which may change from time to time, of *prescription drugs* which *PIC*, in its sole discretion, after consideration of recommendations from *PIC's* Pharmacy and Therapeutics Quality Management Subcommittee, has established for use with this *contract*.

Habilitative Therapy — Therapy provided to develop initial functional levels of movement, strength, daily activity, or speech.

Health Care Services — Medical or behavioral services including pharmaceuticals, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or *provider* visits.

Health Plan

Health insurance coverage offered in the individual market or a small group health plan offered in the small group market, that provides *essential health benefits*, all within the meaning of the *Affordable Care Act.* A health plan does not include coverage that is excepted benefits under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Homebound

When *you* are unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.

Hospital

A facility that provides diagnostic, medical, therapeutic, and surgical services by or under the direction of *physicians* and with 24-hour registered nursing services. The *hospital* is not mainly a place for rest or *custodial care*, and is not a nursing home or similar facility.

Incurred

Services and supplies rendered to a *member* are considered to be "*incurred*" at the time or date the service or supply was actually purchased or provided.

Infertility

Inability to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

1. One year, if *you* are a female under age 35 or a male of any age, or
2. Six months, if *you* are a female age 35 or older,

provided that *your infertility* is not related to voluntary sterilization or failed reversal of voluntary sterilization,

Injury

Bodily damage other than *sickness*, including all related conditions and recurrent symptoms.

Investigative

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

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any authoritative compendia as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care *providers* in the applicable specialty as determined by a sampling of *providers*, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.

Maintenance Care

Care that is not *habilitative* or *rehabilitative therapy* and there is lack of documented significant progress in functional status over a reasonable period of time.

Medical Literature	Articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally accepted scientific standards and must not use case reports to satisfy this criterion.
Medically Necessary	Any *health care services*, *preventive health care services*, and other preventive services that *PIC*, in its discretion and on a case by case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for the diagnosis or condition; and the care must: 1. Be consistent with the medical standards and generally accepted practice parameters of *providers* in the same or similar general specialty as typically manages the condition procedure or treatment at issue; and 2. Help restore or maintain *your* health; or 3. Prevent deterioration of *your* condition; or 4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
Member	A *subscriber* or *dependent* who is enrolled under this *contract*.
Minimum Essential Coverage	Health care coverage as defined by the *Affordable Care Act* and codified in the Internal Revenue Code § 5000A(f), and any related regulations as they may be amended from time-to-time; which includes, but is not limited to, certain government-sponsored programs including a standard basic health plan (BHP) within the meaning of the *Affordable Care Act*, employer-sponsored plans, health plans offered in the individual market in a state; and which, if it is an employer-sponsored plan, provides minimum value, meaning that the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs.
Net Price	*PIC's* cost for insulin, including any rebates or discounts received by or accrued directly or indirectly to *PIC* from a drug manufacturer or pharmacy benefit manager.
Non-Participating Provider	A clinic, *physician*, *provider*, or facility that is licensed but is not a *participating provider*.
Non-Participating Provider Benefits	Coverage for *health care services* provided by licensed *providers* other than *participating providers*. With *non-participating provider benefits*, *you* are financially responsible for a *deductible*, *coinsurance*, and any amount in excess of the *PIC non-participating provider reimbursement value.*
Out-of-Pocket Limit	The maximum amount of money *you* must pay in *copayments*, *coinsurance* and *deductibles* before *PIC* pays remaining *eligible charges*. If *you* reach benefit, day, or visit maximums, *you* are responsible for amounts that exceed the *out-of-pocket limit*.
Orthognathic Surgery	Surgical manipulation of the elements of the facial skeleton to restore the proper anatomic and functional relationship in patients with dentofacial skeletal anomalies.
Participating Provider	A licensed clinic, *physician*, *provider* or facility that is directly contracted to participate in the specific *PIC participating provider* network designated by *PIC* to provide benefits to *members* enrolled in this *PIC contract*. The participating status of *providers* may change from time to time. *Participating providers* may also be offered from other Preferred Provider Organizations that have contracted with *PIC*.
Participating Provider Benefits	Coverage for *health care services* provided through *participating providers*.

Pediatric acute-onset neuropsychiatric syndrome (PANS)	A class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.
Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)	A condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.
Physical Disability	A condition caused by a physical *injury* or congenital defect to one or more parts of *your* body that is expected to be ongoing for a continuous period of at least two years from the date the initial proof is supplied to *PIC* and as a result *you* are incapable of self-sustaining employment and are dependent on the *subscriber* for a majority of support and maintenance. An illness by itself will not be considered a *physical disability* unless adequate separate proof is furnished to *PIC* for *PIC* to determine that a *physical disability* also exists as defined in the preceding sentence.
Physician	A licensed Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Optometry, or Doctor of Chiropractic.
PIC	PreferredOne Insurance Company.
PIC Non-Participating Provider Reimbursement Value	The amount that will be paid by *PIC* to a *non-participating provider* for a non-*emergency* service is the least of the following: 1. a percentage of the *non-participating provider's* charge; 2. a percentage of an amount based on prevailing reimbursement rates or marketplace charges, for similar services and supplies, in the geographic area; 3. a percentage of the amount agreed upon between *PIC* and the *non-participating provider*; or 4. a percentage of the Medicare or other federal government program allowed amount in the geographic area in which the service is performed. If one or more of the above options for determining the *PIC non-participating provider reimbursement value* is not readily available, *PIC* may, at its discretion, determine the *PIC non-participating provider reimbursement value* based on the least of the remaining options. If the amount billed by the *non-participating provider* is greater than the *PIC non-participating provider reimbursement value*, *you* must pay the difference. This amount is in addition to any *deductible* or *coinsurance* amount *you* may be responsible for according to the terms of this *contract*. If *health care services* are delivered to *you* via telemedicine by a distant site *non-participating provider*, *PIC* will reimburse such *non-participating provider* on the same basis and at the same *PIC non-participating provider reimbursement value* as would apply if the *covered services* had been delivered in person by the distant site *non-participating provider*.
Post Service Claim	A request for payment of benefits that is made by *you* or *your* authorized representative after services are rendered and in accordance with the procedures described in this *contract*.
Premium	The total payment that *PIC* requires be paid by *you* or on *your* behalf for the provision of the *covered services* listed in this *contract*.
Prescription Drug	A drug approved by the FDA for use only as prescribed by a *provider* properly authorized to prescribe that drug.
Pre-Service Claim	A claim related to services that have not yet been received, and require a request for pre-certification for services that is made by *you* or *your* authorized representative in accordance with the procedures described in this *contract*.

Preventive Health Care Services

The *covered services* that are described in the Preventive Contraceptive Methods and Counseling for Women section and the *Preventive Health Care Services* section of this *contract*.

Primary Care Practitioner

A doctor of medicine, physician's assistant or nurse practitioner who is licensed or otherwise qualified under applicable law, who provides primary care services in the family medicine, internal medicine, OB/GYN or pediatrics areas of medical practice.

Provider

A health care professional, *physician*, or facility licensed, certified, or otherwise qualified under state law that delivers the *health care services* to *you*.

Qualified Health Plan

Health insurance coverage or a group health plan that MNsure certifies meets the criteria for certification required under the *Affordable Care Act*; that provides *essential health benefits*; and is offered by a health insurance issuer that meets the requirements of Section 1301(a)(1)(c) of the *Affordable Care Act*, and any related regulations as they may be amended from time-to-time. A *qualified health plan* does not include catastrophic coverage as defined by the *Affordable Care Act*.

Qualified Individual

An individual whom MNsure determines has met the eligibility requirements for enrolling through MNsure in a *qualified health plan* in the individual market, which requirements include, but are not limited to, citizenship, national status, or lawful presence in the United States; residency in a MNsure service area served by this *contract*; and not being incarcerated. Such residency requirement does not apply to *dependents.* An individual who, at the time of enrollment, is incarcerated, other than incarceration pending the disposition of charges, is not a *qualified individual*.

Reconstructive

Medically necessary surgery to restore or correct:

1. a defective body part, when such defect is incidental to or resulting from *injury*, *sickness*, or prior surgery of the involved body part; or
2. a covered dependent child's congenital disease or anomaly which has resulted in a functional defect as determined by a *physician*.

Reconstructive Surgery Following a Mastectomy

Coverage for *members* receiving *covered services* under *PIC* in connection with a mastectomy and who elect breast reconstruction in connection with such mastectomy will include:

1. all stages of reconstruction of the breast on which the mastectomy has been performed if the mastectomy was determined to be *medically necessary* by the attending *physician*;
2. surgery and reconstruction of the other breast to produce symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of mastectomy, including lymphedemas.

Rehabilitative Care

Skilled restorative service that is rendered for the purpose of maintaining and improving functional abilities, within a predictable period of time (generally within a period of 6 months), to meet a *member*'s maximum potential ability to perform functional daily living activities. Not considered *rehabilitative care* are: *skilled nursing facility* care; home health services; speech, physical, and occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional ability maintenance and improvement is not anticipated.

Rescission

A cancellation or termination of coverage that has retroactive effect. A cancellation or termination of coverage is not a *rescission* if:

1. the cancellation or termination has only a prospective effect,
2. the cancellation or termination is caused by *your* failure to timely pay *your* required *premiums*, or
3. the cancellation or termination is requested by *you* or *your* authorized representative and *PIC*, in its sole discretion, agrees to allow such request.

Residential Treatment Facility	A facility that is licensed by the appropriate state agency and that provides 24 hour a day care, supervision, food, lodging, rehabilitation, or treatment for *sickness* related to mental health and substance use disorders.
Risk Allowance and Risk Sharing	*Risk allowance* means that a percentage of the reimbursement to a *participating provider* is held back, paid or prepaid, as applicable. The amount withheld, paid or prepaid generally will be less than 20% of the *fee schedule* amount. *Risk sharing* is a *participating provider* payment method in which certain per *member* per month or alternative cost or performance targets are agreed to and, at the end of a period, the parties to the arrangement share in some or the entire amount by which the actual costs, savings or performance exceed or are less than the target.
Routine Patient Costs	The cost of any *covered services* that would typically be covered if *you* were not enrolled in an approved *clinical trial. Routine patient costs* do not include: 1. the cost of the *investigative* item, device, or service that is the subject of the approved *clinical trial*. 2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management. 3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Sickness	Includes physical or mental illness or disease.
Skilled Care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to provide care or assess the *member's* changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for *skilled care*.
Skilled Nursing Facility	A Medicare licensed bed or facility (including an extended care facility, *hospital* swing-bed, and transitional care unit) that provides *skilled care*.
Specialist	*Providers* other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics.
Specialty Drugs	Injectable and non-injectable *prescription drugs*, as determined by *PIC*, which have one or more of the following key characteristics: 1. frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes; 1. intensive patient training and compliance assistance are required to facilitate therapeutic goals; 2. there is limited or exclusive product availability and/or distribution; 3. there are specialized product handling, storage and/or administration requirements; or 4. are produced by living organisms or their products.
Standard Reference Compendia	Any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.
Stepchild(ren)	A natural or adopted child of the *subscriber's* lawful spouse.
Subscriber	The individual who submits an application for coverage, which may include application for coverage of any eligible *dependents* that the *subscriber* wishes to enroll, and, at the time of such application, is responsible for payment of *premium* and is not entitled to Part A or enrolled in Part B of Medicare.
Toileting	Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
Transferring	Moving into or out of a bed, chair or wheelchair.
Transplant Services	Transplantation (including retransplants) of the human organs or tissue, including all related post-surgical treatment and drugs and multiple transplants for related care.

Unauthorized Provider Services

Unauthorized provider services are *incurred* when a *member* receives *health care services*:

1. from a *non-participating provider* at a *hospital* or ambulatory surgical center that is a *participating provider*, when the services are rendered:
   a. due to the unavailability of a *participating provider*;
   b. by a *non-participating provider* without the *member*'s knowledge; or
   c. due to the need for unforeseen *health care services* arising at the time the *health care services* are being rendered;
2. from a *non-participating provider* in a *participating provider's* practice setting under circumstances not described in clause 1.
3. from a *participating provider* that sends a specimen taken from the *member* in the *participating provider's* practice setting to a laboratory, pathologist, or other medical testing facility that is a *non-participating provider*; or
4. not described in clause 3. that are performed by a *non-participating provider*, if a referral for the *health care services* is required by *PIC.*

The services described in clauses 2. to 4., are not *unauthorized provider services* if the *member* gives advance written consent to the *provider* acknowledging that the use of the *non-participating provider*, or that the *health care services* to be rendered, may result in costs not covered by *PIC*.

Unauthorized provider services do not include *emergency services* as defined in Minnesota §62Q.55, subdivision 3.

Urgent Care Center

A licensed health care facility that is designed primarily to offer and provide immediate, short-term medical care for minor immediate medical conditions not on a regular or routine basis.

We, Us, Our

Refers to *PIC*.

Web Based (Online) Care

Care provided by designated *participating providers* performed without physical face to face interaction, but through electronic (including telephonic) communication allowing evaluation, assessment and the management of services that leads to a treatment plan provided by a *participating provider* who is a licensed *physician* or a *participating provider* who is a qualified licensed health care professional. A list of *web based (online) care participating providers* may be obtained by calling *PIC* Customer Service or by checking the PreferredOne website at www.preferredone.com.

For purposes of this *contract*, a *participating provider* who contracts to be a designated *web based (online) care participating provider* shall not be treated or construed as performing telemedicine at a distant site.

You/Your

Refers to *member.*

Notice Concerning Policyholder Rights in an Insolvency Under the Minnesota Life and Health Insurance Guaranty Association Law

If the insurer that issued *your* life, annuity, or health insurance policy becomes impaired or insolvent, *you* are entitled to compensation for *your* policy from the assets of that insurer. The amount *you* recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South 7th Street
Minneapolis, MN 55402
Telephone Number: 612.322.8713; Fax Number: 402.474.5393; polsen@clinewilliams.com.

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If *your* claim exceeds the guaranty association's limits, *you* may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Notice to Enrollee

Your Rights Related to *Your* Mental Health and Substance Use Disorder Benefits

The Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, the Affordable Care Act and Minnesota Statutes § 62Q.47 give *you* certain rights related to *your* mental health and substance use disorder (MH/SUD) benefits. In general, *your* MH/SUD benefits must be substantially the same as *your* medical and surgical (Med/Surg) benefits.

Your coverage for MH/SUD benefits and Med/Surg benefits must be subject to substantially the same cost sharing requirements. In addition, *your* coverage cannot contain a cost sharing requirement that applies to MH/SUD benefits but not to Med/Surg benefits. *Your* coverage for MH/SUD benefits and Med/Surg benefits must be subject to substantially the same limitations. *Your* ability to access your MH/SUD benefits and Med/Surg benefits must be subject to substantially similar conditions.

In general, *your* plan cannot impose any of the following: (a) higher copayments and deductibles for MH/SUD compared to Med/Surg; (b) greater limits on the number of visits for MH/SUD, compared to Med/Surg; and (c) prior authorization requirements for MH/SUD that are more restrictive than those for Med/Surg.