

Health Partners PPO 3M Medical Plan

(Effective January 1, 2012)

Summary Plan Description

Annual Notifications

Women's Health and Cancer Rights Act

Under the Federal Women's Health and Cancer Rights Act of 1998 you are entitled to the following mastectomy-related services in a manner determined in consultation with the attending physician and the patient:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Protheses; and
4. Treatment of physical complications of mastectomy, including lymphedema.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Call the Claims Administrator for more information.

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Introduction

This booklet is the summary plan description ("SPD" or "Summary") for the HealthPartners PPO 3M Medical Plan ("Plan"). It is based on plan provisions effective January 1, 2012. This Summary, together with any separate amendments and other documents, is also the official plan document for the Plan.

To fully understand your benefits, you must read this Summary carefully. It is important that you read the entire Summary. You should keep this Summary for future reference. Share this Summary with your family, particularly your spouse/domestic partner, and make sure they have read it along with yourself and understand it and your responsibilities. One of your responsibilities is to timely provide any required notice or information as described in this Summary and other benefit communications. Another responsibility is to make sure 3M has your current mailing address and to timely notify 3M of any change in your address. Failure to follow the terms of the Plan or satisfy any Plan requirements can result in delay, reduction, denial or termination of coverage and/or benefits.

Neither the receipt of this Summary nor its use of the term "you" indicate that you are eligible for benefits under the Plan. Only those individuals who satisfy the eligibility requirements and other criteria contained in the Plan are eligible for benefits.

The information in this Summary may not be relied on as tax advice for any purpose. 3M does not guarantee any specific tax consequences. Ultimately, it is your responsibility to determine whether each benefit to you under this Plan is excludable for tax purposes. For information on how applicable tax law may apply in your personal situation you should consult your own qualified tax advisor.

Neither the terms of the Plan nor the benefits provided under the Plan shall be a term of employment of any individual. This Summary and the Plan shall not be deemed an employment contract. Participation in the Plan does not constitute a guarantee of employment.

Customer Service

Questions?

The Claims Administrator's customer service staff is available to answer your questions about your plan.

Monday through Friday: 7 a.m. - 7 p.m. CST
Central Standard Time (CST)

Hours are subject to change without prior notice.

Customer Service Telephone Number

Claims Administrator: (877) 435-7613 (toll free) or (952) 883-5144

24-Hour Nurse Advice Line Telephone Number

(877) 435-7613 (toll free) or (952) 883-5144

This number is used to access health care advice 24 hours a day – seven days a week.

Healthy Pregnancy Telephone Number

(877) 435-7613 (toll free) or (952) 883-5144

This number is used to enroll in the Healthy Pregnancy program.

Stop-Smoking Support Telephone Number

(800) 311-1052 (toll free) or (952) 883-7800

This number is used to enroll in the Stop-Smoking Support.

HealthPartners Website

www.healthpartners.com/3M

Claims Administrator's Mailing Address

Claims review requests, and written inquiries may be mailed to the address below:

HealthPartners Administrators, Inc.
P.O. Box 750
Minneapolis, MN 55440-1309

For prior certification requests please contact CareCheck call:

(800) 942-4872 (toll free) or (952) 883-5800

Monday through Friday: 8 a.m. - 5 p.m. CST
Central Standard Time (CST)

You may also write CareCheck at the following address:

CareCheck
Quality Utilization Management Department
P.O. Box 1309
Minneapolis, MN 55440-1309

Medical Appeals

Send a written request to:

HealthPartners Administrators, Inc.
P.O. Box 750
Minneapolis, MN 55440-1309

**Claims Administrator for
Prescription Drug**

CVS/Caremark
P.O. Box 52154
Phoenix, AZ 85072-2154
(800) 700-5257 (toll free)
www.caremark.com

Monday through Friday: 6 a.m. - 9 p.m. CST
Saturday and Sunday: 8 a.m. - 7 p.m. CST
Central Standard Time (CST)

Hours are subject to change without prior notice.

Prescription Drug Appeals

CVS/Caremark, Inc.
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: (866) 443-1172 (toll free)

**Claims Administrator for
Routine Vision**

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195 (toll free)
www.vsp.com/3M

Monday through Friday: 7 a.m. - 9 p.m. CST
Central Standard Time (CST)

Hours are subject to change without prior notice.

**Eligibility and Enrollment
Questions**

3M FIRST Line Center
100 Half Day Road
Lincolnshire, IL 60069-3242
Tel: (888) 611-5500 (toll free)
Fax: (847) 883-9313

Monday through Friday: 8 a.m. - 6 p.m. CST
Central Standard Time (CST)

**COBRA and Direct Bill
Questions**

3M FIRST Line Center
100 Half Day Road
Lincolnshire, IL 60069-3242
Tel: (888) 611-5500 (toll free)
Fax: (847) 883-9313

Monday through Friday: 8 a.m. - 6 p.m. CST
Central Standard Time (CST)

**General Human Resource
Questions**

North America HR Service Center
(877) 496-3636 (toll free)
(651) 575-5000 (Twin Cities)

Monday through Friday: 7:30 a.m. - 5 p.m. CST
Central Standard Time (CST)

Eligibility

Employee Eligibility

You are eligible to participate in the Plan only if you are classified by 3M or a participating 3M affiliate on both payroll and personnel records as a regular full- or part-time employee of 3M or a participating 3M affiliate. You are not eligible to participate in the Plan if:

- You are subject to a collective bargaining agreement unless and to the extent that the agreement provides for your participation;
- You are classified by 3M or a participating 3M affiliate as a temporary employee;
- You are classified by 3M or a participating 3M affiliate as a leased employee, independent contractor, contingent worker, service worker, consultant, contract worker, agency worker, freelance worker, shared employee or a person other than a common law employee, regardless of your actual legal status;
- Your compensation is not reported on a Form W-2 issued by 3M or a participating 3M affiliate;
- You are covered by a contract or other written agreement that provides you are not eligible for the Plan or employee benefits; or
- You are employed by an affiliate that is not a participating employer.

An individual who becomes a regular full- or part-time employee of 3M or a participating 3M affiliate as a result of an acquisition, merger, consolidation or other similar transaction shall not be eligible for the Plan unless the Plan Administrator declares such employee to be eligible.

3M or a participating 3M affiliate's classification of an individual is conclusive and binding for purposes of determining eligibility to participate in this Plan and shall be made solely in the discretion of 3M or a participating 3M affiliate. No reclassification or determination of a person's status with 3M or a participating 3M affiliate, for any reason, without regard to whether it is initiated by a court, governmental agency or otherwise and without regard to whether or not 3M or a participating 3M affiliate agrees to such reclassification or determination, shall make the person retroactively or prospectively eligible for benefits. However, 3M or a participating 3M affiliate, in its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Dependent Eligibility

If you are covered under the Plan as an eligible employee, your eligible dependents also may be covered. You may be asked to provide evidence substantiating dependent status. Failure to provide such proof to the satisfaction of the Enrollment Administrator will result in termination of coverage. In the event your enrolled dependent becomes ineligible for the Plan, you must notify the Enrollment Administrator within 31 days of the date of the event resulting in ineligibility.

Spouses and domestic partners who are eligible for coverage through their employer are expected to choose that coverage as their primary coverage, which includes a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA). You may enroll your spouse or domestic partner in coverage under this Plan as secondary coverage. If your spouse or domestic partner does not select the coverage available from his/her employer and instead elects this Plan as primary coverage, an additional medical premium, or spousal surcharge, will apply to your spouse's or domestic partner's coverage. This additional medical premium will apply even if your spouse or domestic partner is employed by 3M or has retired from 3M and the employer-provided coverage is through a 3M medical or retiree medical plan. In

such case, your spouse or domestic partner is expected to enroll in their own 3M medical or retiree medical plan coverage as primary.

Your eligible dependents include:

1. Your lawfully married spouse

- For your spouse to be eligible, your spouse must be of the opposite sex and the marriage (including a common law marriage) must be recognized as a legally valid marriage by the state in which you reside.

Note: Upon divorce or legal separation, a spouse ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage to your former spouse.

2. Your eligible domestic partner

Note: Domestic Partner Benefits are not available to employees in Puerto Rico.

- An individual is eligible as your domestic partner only if one of the following applies:
 - You and your domestic partner are members of the same sex and have a state-recognized union, such as: (1) you are legally married in a state that permits the marriage between members of the same sex, (2) you have entered into a legal, state-sanctioned marriage alternative arrangement between members of the same sex (such as a civil union), or (3) you have registered as domestic partners in a state which has a domestic partner registration process; **OR**
 - You and your domestic partner (1) are members of the same sex, (2) have resided together for at least 12 consecutive months immediately preceding the signing of the required Affidavit and intend to continue to reside together, (3) are not related by blood closer than would bar marriage in your state of residence, are not legally married to anyone, and are the sole partners of each other, (4) are both 18 years of age or older, and are mentally competent to consent to contract, (5) are in a committed relationship of mutual support and are jointly responsible for your common welfare, and (6) reside in a state whose laws do not permit marriage between members of the same sex; **OR**
 - If marriage is available to you and your domestic partner in the state in which you reside, you and your domestic partner must take advantage of that option to be certified as domestic partners. If you move to a state that permits same-sex marriages or the state in which you reside changes from one that does not permit such marriages to one that does, you and your domestic partner must marry within one year of its availability in order to remain certified as domestic partners.
 - For your domestic partner to be eligible for coverage, you must submit a domestic partner affidavit and certify your domestic partner's tax status when you add them to coverage and during annual enrollment.

Note: If (1) you terminate your domestic partner relationship, or (2) your domestic partner ceases to satisfy the criteria above for an eligible domestic partner, you must complete a life event or call the 3M FIRST Line Center.

3. Your eligible dependent child(ren)

A child is eligible only if all of the following are met:

- The child is under age 26; **and**
- The child is:
 - your biological child, or
 - a child legally adopted by you or placed with you for adoption, or
 - your step child, or
 - a child for whom you have assumed legal responsibility (guardianship), or
 - a child of your domestic partner.
- The value of coverage provided to a child for whom you have assumed legal responsibility (guardianship) or to a child of your domestic partner who is not your qualified tax dependent shall be imputed as income to you and subject to federal income tax. The value of coverage provided to all non-qualified tax dependent children may also be subject to state income taxes. You should consult with your tax advisor for guidance on how the tax laws apply to your situation.
- When adding a domestic partner's child or a child for whom you have a legal guardianship you will be required to certify online as to the tax dependent status of your child. This will also be required during annual enrollment each year. You may also call the 3M FIRST Line Center to complete the enrollment. If the tax dependent status changes for a child covered under the Plan, you must notify 3M immediately by contacting the 3M FIRST Line Center.

Extending a Child's Eligibility Due to Disability

A dependent child's coverage may continue after reaching age 26 if the Claims Administrator approves coverage and determines that:

- The child continues to satisfy the eligibility requirements listed above for dependent children (except for the age requirement); and
- The child is incapable of sustaining employment; and
- The child has a physical or mental disability.

To be eligible for this continued coverage, you must submit an application to your Claims Administrator before the child's 26th birthday providing evidence of the disability. You can obtain the forms by calling your Claims Administrator. If the disability status is approved, the Claims Administrator will periodically request that you submit proof that your child continues to satisfy all eligibility/disability requirements. Failure to provide requested information may result in loss of coverage for your dependent.

Qualified Medical Child Support Orders

You may be required under a qualified medical child support order (QMCSO) to cover your child under the Plan. If a medical child support order is issued for your child, he or she will be eligible for coverage if the Enrollment Administrator determines that the order is qualified as a QMCSO. You must notify the Enrollment Administrator as soon as possible if an order is issued for your child. The Plan has procedures for determining whether a medical child support order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Enrollment Administrator.

Ineligible Dependents

Ineligible dependents include but are not limited to the following:

- Parents and grandparents
- Spouses, domestic partners and children of an eligible child
- Grandchildren unless they meet the child eligibility requirements listed above
- Foster children or children in voluntary/temporary care arrangements
- A child for whom your parental rights have ended in accordance with state law

Covering ineligible individuals under the Plan (such as enrolling an ineligible individual as your dependent or failing to notify the Enrollment Administrator that a dependent has ceased to be eligible) or otherwise making a misrepresentation regarding the basis for Plan coverage to 3M, its Plan, or its administrator(s), is a violation of company policy and is considered fraud under the terms of this Plan. The Plan reserves the right to cancel coverage and deny claim payments retroactively as well as recover any and all benefit payments made on behalf of an ineligible individual. In addition, 3M reserves the right to take disciplinary action, up to and including termination from the Plan of the employee and all dependents and/or termination from employment of the employee to the extent permitted by law, and all other civil and criminal recourse, for such actions.

Enrolling in the Plan

Annual Enrollment

Each year, you will have the opportunity to review your coverage and make adjustments to meet any changes in your life. Annual benefits enrollment occurs every year. Changes you make during the annual enrollment period become effective the following January 1 and cannot be changed during a subsequent calendar year unless you have a qualifying change in status or special enrollment event, as described below. Likewise, if you drop coverage at annual enrollment, you cannot re-elect coverage until the next annual enrollment period. If you do nothing at annual enrollment and if you have coverage under 3M's Benefit Program, that coverage will continue, as previously elected, on the following January 1.

Enrolling in the Plan as a New Employee

As a new employee and participant in the 3M Benefits Program, you select coverage when you enroll online through 3M Source, our employee portal. You can elect the coverage that you and your eligible dependents will have for the remainder of that calendar year. Each subsequent year, you have the opportunity to make a new plan choice during the annual 3M Benefit Enrollment period.

New employees must enroll within 14 days of employment. If you do not enroll yourself and your eligible dependents within 14 days of employment, you will be defaulted to a plan 3M selects for you and you will not be able to enroll your eligible dependents until the next annual enrollment period.

Enrolling in the Plan as a Domestic Partner

To enroll your eligible domestic partner and/or his/her eligible child(ren) in 3M benefits for the first time, you will be asked to certify a domestic partner affidavit and the tax status of your domestic partner and/or your domestic partner's child(ren).

Cost of Coverage

You and 3M share the cost of health coverage for you and your enrolled dependents. Your cost for coverage depends on the coverage category you choose. You pay your share of the cost of coverage with pre-tax dollars through automatic payroll deductions. By enrolling in the Plan, you authorize these automatic pre-tax payroll deductions. If pre-tax payroll deductions are not feasible, you are responsible for paying the premium on an after-tax basis for the coverage category you have elected by the required deadline.

The cost of coverage is generally established prior to the beginning of each calendar year and is subject to change at any time. 3M reserves the right to amend, modify or terminate the Plan at any time and for any reason, and this includes but is not limited to the right to change or eliminate 3M's contribution towards the cost of coverage.

You have the option of electing one of four (4) coverage levels:

- Employee only
- Employee plus spouse
- Employee plus child or children
- Family coverage (Employee, spouse and dependent child (ren))

Tobacco-Free Discount

Choosing to be tobacco free is one of the most significant investments you can make to improve the quality of your long-term health. You and your covered dependents are eligible to qualify for a tobacco-free discount on your medical plan premiums as part of the 3M Wellness Program. If you are tobacco free you may be able to qualify for a \$30 per month discount. If all your covered dependent(s) are tobacco free you may be able to qualify for an additional \$30 per month discount. The maximum tobacco-free discount you can qualify for each month is \$60 assuming both you and all your covered dependents are tobacco free.

When you enroll in the plan, you will be asked to certify that you and/or your covered dependent(s) have been tobacco free for the past 12 months and will remain tobacco free. You must complete the certification to qualify for the discount. 3M reserves the right to require proof of tobacco-free status. Misrepresenting your tobacco status is a violation of company policy and is considered fraud under the terms of this Plan.

Alternatively, if you and/or any of your covered dependents are tobacco users, you can qualify for the discount if you have completed a quit smoking/tobacco use program within the 12 months prior to enrollment. You must be able to provide documentation that you and/or any of your covered dependents completed the quit smoking/tobacco use program within the required time period to qualify for the discount.

It's hard to quit using tobacco on your own. That's why 3M Healthy Living provides you and your eligible dependent(s) resources to help you become, and remain, tobacco-free. For more information, logon to 3M Source:

- From the 3M intranet (at work): <http://3msource.mmm.com>
- From the internet (at home): <http://3msource.3m.com>

Spousal Surcharge Premium

3M requires you to pay an additional monthly premium (spousal surcharge) to cover a spouse/domestic partner as a dependent under a 3M medical plan if he or she is offered coverage and has declined medical coverage available through his or her employer.

Domestic Partner Medical and Dental Premiums

Medical and dental premium rates are the same for an employee with an eligible domestic partner and/or a domestic partner's eligible child(ren) as for an employee with a spouse and/or child(ren). While the premium rates are the same, the tax implications of covering a domestic partner and/or a domestic partner's child(ren) may not be the same.

Tax Considerations for Domestic Partners and Domestic Partner's Child(ren)

Eligible Domestic Partner/Domestic Partner Child(ren)

Employees must understand the federal and state tax implications of enrolling an eligible domestic partner and a domestic partner's child(ren) for employer provided health care coverage who is not a qualified tax dependent.

If your eligible domestic partner/domestic partner's child(ren) meets the definition of tax dependent under the Internal Revenue Code:

- Your portion of the cost of health care coverage for your eligible domestic partner/domestic partner child(ren) will be deducted from your pay on a pre-tax basis.
- The value of the coverage provided by 3M will be tax-free to you.

If your eligible domestic partner/domestic partner's child(ren) **does not meet** the definition of tax dependent under the Internal Revenue Code:

- Your portion of the cost of health care coverage for your eligible domestic partner/domestic partner child(ren) will be deducted from your pay on a pre-tax basis.
- The value of the coverage provided by 3M will be treated as taxable income to you . This means 3M must add this imputed income to your W-2 income and subject this income to all applicable federal, FICA, state, local or other payroll taxes. However, the value of coverage provided to you and your eligible dependents remains tax-free. For an estimate of the imputed income for domestic partner/domestic child(ren) coverage, call the 3M FIRST Line Center, (888) 611-5500 (toll free) or (847) 883-0483 outside the United States.

Annual Recertification of Your Domestic Partner and Domestic Partner Child(ren) Tax Status

You will be asked to recertify "tax status" during annual enrollment for any domestic partner or domestic partner's child(ren). Otherwise, your domestic partner's and your domestic partner's child(ren) coverage will default to non-qualified dependent tax status.

Changing Your Coverage

When you have a qualifying change in status, your eligibility records must be updated.

Your plan choice generally remains in effect from January 1 through December 31. You may change your plan option during the annual 3M benefits enrollment each fall (changes are effective January 1 of the following year). Or, if you have a qualifying change in status during the year, you may start or stop coverage and/or change the eligible dependents you cover.

What is a Qualifying Change in Status

Ordinarily, you keep your benefits choices through the end of the plan year without making any changes. However, a “qualifying change in status” is a legitimate change in your status that enables you to change your benefits when the change occurs, even mid-year.

There are specific events which constitute a qualifying change in status and which benefit changes may be allowed for each event. Qualifying change in status rules provide a two-step process for determining whether a change may be made to his/her election during the year. First, a change in status event must have occurred. Second, the requested change must be consistent with the event.

The following events are considered qualifying changes in status:

- A change in employee’s legal marital status, including marriage, divorce, death, legal separation, death of a spouse and the corresponding gain/loss of a dependent child;
- A change in the number of tax dependents, including birth, adoption, placement for adoption and death;
- A change in employment status when health care coverage is gained or lost as a result of the event;
- An involuntary gain/loss of health benefits;
- A dependent satisfies or ceases to satisfy dependent eligibility requirements;
- You or an eligible dependent becomes eligible for Medicare;
- Significant cost change;
- Special enrollment for loss or gain of Medicaid or CHIP coverage; and
- Loss of group health coverage sponsored by governmental or educational institutions.

If the events described above apply to you, you may be eligible to change your health care coverage mid-year. Please note that the IRS mandates that any requested change be due to a gain or loss of coverage eligibility, and that the change must be consistent with the event.

Qualified changes need to be made on the *Your Benefits Resources*[™] website within 31 days of the event date. If you do not have access to the *Your Benefits Resources*[™] website, you may call the 3M FIRST Line Center.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a 3M health plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

3M will also allow a special enrollment opportunity if your or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days - instead of 31 - from the date of the Medicaid/CHIP eligibility change to request enrollment in the 3M group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

If your dependent gains or loses CHIP/Medicaid, you will need to complete a Child Gains or a Child Loses CHIP coverage or to obtain more information, contact the 3M FIRST Line Center at (888) 611-5500 (toll free) or (847) 883-0483 outside the United States.

Loss of Other Coverage

If you previously declined enrollment in the Plan for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your dependents in the Plan if you or your dependents lose eligibility for that other coverage.

You and/or your eligible dependents will be allowed to enroll due to a loss of other coverage if such loss is due to one of the following:

- Termination of employment or reduction in hours;
- Divorce or legal separation;
- Death;
- Cessation of dependent status;
- Loss of HMO or similar coverage because you change your residence or work place and as a result coverage is no longer available;
- Incurring a claim that would meet or exceed a lifetime limit on all benefits;
- The plan is changed so that you, your spouse or your dependents are no longer eligible;
- A situation in which coverage is no longer offered to a class of similarly situated individuals which includes the employee; or
- Employer contributions toward the cost of coverage terminate.

Note: The loss of other coverage must not be due to a failure to pay premiums or termination for cause, such as making fraudulent claims or intentional misrepresentation.

Loss of Medical Assistance (Medicaid) or Children’s Health Insurance Program (CHIP) Coverage

You or your dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

- You or your dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the group member or dependent;
- You must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and
- You or your dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

Eligibility for Premium Assistance

You or your dependents who are eligible but not enrolled in the health plan may enroll for coverage in the health plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children’s Health Insurance Program (CHIP) if all the following conditions are met:

- The employer must submit any required documentation indicating that you and/or your dependents are eligible for premium assistance through Medicaid or CHIP; and
- You or your dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

Exhaustion of COBRA Coverage

If you or a dependent are enrolled in COBRA when you decline coverage under the Plan, you must exhaust your COBRA coverage in order to qualify for special enrollment. COBRA will be deemed to be exhausted for this purpose if it ends for any reason other than your or your dependent’s failure to pay premiums or termination for cause (such as fraud). COBRA would therefore be deemed to be exhausted if it ended for any of these reasons:

- Another employer or responsible entity fails to remit premiums for the coverage as a whole (but not if you or a dependent lose coverage for your or your dependent’s non-payment);
- Loss of HMO or similar coverage because of change in residence or work place that makes coverage unavailable where there is no other COBRA continuation coverage available; or
- Incurring a claim that would meet or exceed a lifetime limit on all benefits.

Gaining a New Dependent

You may also enroll yourself, your spouse and/or a newly eligible dependent, if you gain a new dependent through one of the following:

- Marriage,
- Birth,
- Adoption; or
- Placement for adoption of a child.

Procedure & Deadline to Enroll

To enroll or change your elections because of a special enrollment, you must go to the *Your Benefits Resources*™ website within 31 days of the date on which the special enrollment event occurs. Even if you are enrolled under family coverage, you must go into the *Your Benefits Resources*™ website to add your dependent within 31 days from the date of birth, adoption or placement for adoption.

If you are not a 3M employee or cannot access 3M Source, you may call the 3M FIRST Line Center at (888) 611-5500 (toll free), or (847) 883-0483 outside the United States. Call Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

If you do not complete the special enrollment within the 31-day deadline, you will not be permitted to enroll yourself and/or your eligible dependents until the next annual enrollment, unless you experience another special enrollment event or change in status event. You may be required to supply written proof that you experienced a special enrollment event, such as written evidence of loss of other coverage, a signed marriage certificate, or a signed certification of the birth, adoption or placement for adoption of a child.

Coverage Information

The Plan provides Network Benefits and Out-of-Network Benefits from which you may choose to receive covered services. Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain covered services.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities or vendors which are authorized to provide certain covered services as described in this SPD. Call Member Services at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free) or visit www.healthpartners.com/3M for a current list.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which have entered into an agreement to provide health care services to covered persons.

A provider listing will be sent to you automatically and free of charge. For the most current and complete provider information, contact Member Services or visit www.healthpartners.com/3M.

Out-of-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as network providers.

Described below are the two “network” options available to you under the Plan:

Network Benefits

To obtain Network Benefits for covered services, you must select and receive services from network providers. There are limited exceptions as described in this SPD.

Network. This is the network of participating network providers.

Network Clinics. These are participating clinics providing ambulatory medical services.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Employer changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by out-of-network providers may be considered a covered Network Benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:

1. An acute condition;
2. A life-threatening mental or physical illness;
3. Pregnancy beyond the first trimester of pregnancy;
4. A physical or mental disability defined as an inability, to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

5. A disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits.

Call Member Services at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free) for further information regarding continuity of care benefits.

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free) or check online at www.healthpartners.com/3M for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity, restrictions on access and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally handicapped children; and (3) mental health services provided in the home.

Convenience care scheduled telephone visits must be provided by a designated, network provider.

Contracted convenience care clinics are designated on www.healthpartners.com/3M. You must use a designated convenience care clinic to obtain the convenience care benefit.

Durable medical equipment and supplies must be obtained or repaired by designated vendors.

Non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To receive Network Benefits, weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities.

Call Member Services at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free) for more information on authorization requirements or designated vendors.

Second Opinions for Network Services

If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.

Prescription Drugs and Medical Equipment

Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

Out-of-Network Services

It is your responsibility to notify CareCheck[®] of all services requiring review (see Notification Requirements section). Failure to follow CareCheck[®] procedures may result in a reduction of the maximum coverage available to you under the Plan. You can designate another person to contact CareCheck[®] for you.

Notification Requirements

CareCheck[®] Services

CareCheck[®] is HealthPartners' utilization review program for out-of-network services. CareCheck[®] must pre-certify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over \$3,000, home health services after your visits exceed 30 and skilled nursing facility stays. When you call CareCheck[®], a utilization management specialist reviews your proposed treatment plan. CareCheck[®] provides certification and determines appropriate length of stay, additional days and reviews the quality and appropriateness of care.

Procedure To Follow To Receive Maximum Benefits:

1. **For medical emergencies.** A certification request is to be made by phone to CareCheck[®] as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.
2. **For medical non-emergencies.** A phone call must be made to CareCheck[®] when services requiring pre-certification are scheduled, but not less than 2 working days prior to that date. CareCheck[®] advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within ten days of the decision.

Failure to Comply With CareCheck[®] Requirements

If you fail to comply with the pre-certification requirements for an inpatient confinement, HealthPartners will reduce the eligible inpatient facility charges (hospital only) by 20%. The 20% reduction does not apply to deductibles, co-insurance or out-of-pocket. For inpatient maternity, if no authorization, the payment is not reduced 20% the first 48 hours.

CareCheck[®] Certification Does Not Guarantee Benefits

CareCheck[®] does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the SPD. CareCheck[®] only certifies medical necessity.

Information Needed When You Call CareCheck[®]

When you or another person contacts CareCheck[®], this information is needed:

- The covered person's name, address, phone number, birth date and ID number;
- The attending physician's name, address, and phone number;
- The facility's name, address, and phone number;
- The reason for the services requiring review.

Pre-certification Process

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

How to contact CareCheck[®]

You may call **(952) 883-5800** in the Minneapolis/St. Paul metro area, or **(800) 942-4872** (toll free), from 8 a.m. to 5 p.m. Central Standard Time (“CST”) weekdays. You can leave a recorded message at other times. You may also write CareCheck[®] at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

Dual Surgical Procedures

If more than one surgical procedure is performed during the same operative session, the Plan will allow 100% for the primary procedure and will reduce the allowed amount for each additional procedure according to industry standards. The reduction is due to the non-duplication of facility charges and the efficiencies of having one or more procedures completed at the same time.

When you use a network provider, you will not be billed for the difference between what the Plan allows and the provider’s charge for each additional procedure; however, you may be billed for any applicable out-of-pocket expenses (i.e., copayments, coinsurance and deductibles).

When you use an out-of-network provider, you may be liable for the difference between what the plan pays and the provider’s charge for each procedure, as well as, any applicable out-of-pocket expenses (i.e., copayments, coinsurance and deductibles).

Claims Procedures

Procedures for Reimbursement of Network Services

When you present your identification card at the time of requesting network services from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

Procedures for Reimbursement of Services

Claim Forms

If claim forms are needed, please contact the Claims Administrator at (952) 883-5144 or toll free at (877) 435-7613 (toll free) or online at www.healthpartners.com/3M. For hearing-impaired individuals, call (952) 883-5127 (TDD). You must submit claims to the Claims Administrator for out-of-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.

Proof of Loss

Claims for services must be submitted to the Claims Administrator at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued, the deadline for claim submission is 180 days. The Claims Administrator may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to:

Claims Department
HealthPartners, Inc.
P.O. Box 1289
Minneapolis, MN 55440-1289

Time of Payment of Claims

Benefits will be paid under the Plan within a reasonable time period.

Payment of Claims

You cannot assign your benefits under this Plan to anyone else or otherwise encumber or alienate the payments to be made under this Plan. The Employer is not required to reimburse anyone other than you for covered services when you use out-of-network providers. It is your responsibility to arrange for the payment of those expenses and then get reimbursed from the Plan. Except as may be required by law, your benefits under the Plan are not subject to the claims of your creditors.

Physical Examinations and Autopsy

In the event the Claims Administrator or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Claims Administrator or Plan Sponsor may request this information from you or your legal representative. Failure to submit the required information may result in denial of your claim.

Time of Notification to Claimant of Claims

The only claims under your Plan that meet the definition of “pre-service”, are those that require pre-certification by CareCheck[®]. For purposes of this claim and appeal process, all other claims, including requests for prior authorization, are considered “post-service” claims.

Pre-service claims (pre-certification requests)

When a request to CareCheck[®] for pre-certification for a non-urgent service is requested, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Claims Administrator determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a request to CareCheck[®] for pre-certification for an urgent service is requested, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

Post-service Claims

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

Claim Denials and Claim Appeals Process for Pre-service Claims

If your request to CareCheck[®] for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal. You may also have the right to an external review described below. You must exhaust this appeal process prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

First Level Appeal to the Claims Administrator

You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Claims Administrator will review your appeal and will notify you of its decision in accordance with the following timelines:

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

Second Level of Appeal to the Claims Administrator

If after the first level of appeal your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Claims Administrator and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

Claim Denials and Claim Appeals Process for Post-service Claims

(all claims except requests from for CareCheck[®] pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal. You may also have the right to an external review described below. You must exhaust the first and second levels of appeal prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

First Level Appeal to the Claims Administrator

You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Claims Administrator will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

All notifications described above will comply with applicable law.

Second Level of Appeal to the Claims Administrator

If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Claims Administrator and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

The Claims Administrator will review your appeal and will notify you of its decision within 30 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

External Review Procedures

You or your authorized representative must request an external review within 4 months of the adverse decision. All external reviews are conducted by an accredited Independent Review Organization (IRO). If your claim is denied because of an adverse benefit determination, you have the right to request an external review, as described below.

An adverse benefit determination is a denial, reduction, or termination of, or failure to provide or make payment for a benefit for any of the following reasons:

- Failure to provide or make payment for a benefit based on a determination that the person is not eligible to participate in the Plan.
- Failure to provide or make payment for a benefit based on a utilization review.
- Failure to provide or make payment for a benefit based on a determination that the benefit is experimental or investigational.

In addition, an adverse benefit determination includes a rescission of coverage. A rescission is a discontinuance or cancellation of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively because of a failure to pay premiums or contributions on a timely basis.

If you have an adverse benefit determination as defined above, you have the right to request external review. To initiate the external review process, you may submit a written request for an external review to the Claims Administrator:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon receipt of the request for external review, the IRO must provide immediate notice of the review to the Covered Person and to the Claims Administrator. Within 10 business days, the Covered Person and the Claims Administrator must provide the reviewer with any information they wish to be considered. The Covered Person (who may be assisted or represented by a person of their choice) and the Claims Administrator shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.

An external review must be made as soon as possible, but no later than 40 days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Covered Person and to the Claims Administrator:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

If you have a medical condition that meets the requirements for an urgent care claim or if the final internal adverse benefit determination concerns admission, availability of care, continued stay or health care item or service for which you received emergency services and you have not yet been discharged, you may be eligible for an expedited external appeal review. The difference between an external appeal review and an expedited external appeal review is the time frame allowed for making a determination. For an expedited external appeal review, the IRO will notify you and the Claims Administrator of the final external review determination within 72 hours after the IRO receives the request for the expedited external appeal review.

Benefit Chart

This section lists covered services and the benefits the Plan pays. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of this Summary Plan Description and must be medically necessary. Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available online at www.healthpartners.com/3M or by calling Customer Service at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free).

Benefit Features, Limitations, and Maximums

Networks:

- | | |
|------------------------|------------------------------------|
| ▪ In-Network Providers | HealthPartners Open Access Network |
|------------------------|------------------------------------|

Benefit Features

Your Liability

Copays

- | | |
|---|-----------------|
| ▪ Emergency room facility copay
(Copay is waived if you are admitted within
24 hours) | \$100 per visit |
|---|-----------------|
-

Medical Deductible

If you have family coverage (two or more members), each member is only responsible for satisfying their individual medical deductible, which is accumulated toward the family medical deductible. One member cannot satisfy the entire family medical deductible.

- | | |
|----------------------------|--------------------------------------|
| ▪ In-Network Providers | \$350 per person per calendar year |
| | \$700 per family per calendar year |
| ▪ Out-of-Network Providers | \$700 per person per calendar year |
| | \$1,400 per family per calendar year |

The In-Network Provider Deductible is accumulated separately from the Out-of-Network Provider Deductible. They do not cross apply.

Benefit Features

Limitations and Maximums

Medical Out-of-Pocket Maximums

If you have family coverage (two or more members), each member is only responsible for satisfying their individual medical out-of-pocket maximum, which is accumulated toward the family medical out-of-pocket. One member cannot satisfy the entire family medical out-of-pocket maximum.

- In-Network Providers
\$2,000 per person per calendar year
\$4,000 per family per calendar year
- Out-of-Network Providers
\$3,000 per person per calendar year
\$6,000 per family per calendar year

The In-Network Provider Out-of-Pocket Maximum is accumulated separately from the Out-of-Network Provider Out-of-Pocket Maximum. They do not cross apply.

The following items are applied toward the medical Out-of-Pocket Maximum:

- Medical coinsurance
- Medical deductibles
- Medical copays

The following items are NOT applied toward the medical Out-of-Pocket Maximum:

- Expenses that are not covered under the Plan
- Any amount in excess of the allowed amount
- The reduction in benefits for failure to comply with CareCheck® requirements will not apply toward the Out-of-Pocket Limit
- Expenses for hearing aids and fittings that exceed the maximum benefit limit
- Routine vision feature benefits
- Prescription drug expenses

Lifetime Maximum

- Total benefits paid to all providers combined Unlimited
-

Benefit Descriptions

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

Acupuncture

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Acupuncture when performed by a physician, osteopaths, podiatrists, or practitioner specially trained and licensed to perform acupuncture	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- The Plan will cover up to 25 visits per person per calendar year for all networks combined. Acupuncture services may also be denied prior to the 25 visit limit if continuation of the services is not considered medically necessary.
- The Plan will cover acupuncture when used as anesthesia as long as it is administered by an MD anesthesiologist trained to practice acupuncture.

NOT COVERED:

- The Plan does not cover acupuncture treatment for phlebitis, nerve deafness, hypotension, hypertension, alopecia, allergies, weight loss and smoking cessation
 - Please refer to the General Exclusions section
-

Ambulance

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the condition ▪ Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse 	90% after you pay the deductible.	90% after you pay the deductible.

NOTES:

- Please refer to the Notification Requirements section.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the allowed amount for medically necessary ground ambulance.

NOT COVERED:

- Transportation services that are not medically necessary for basic or advanced life support
 - Transportation services that are mainly for your convenience
 - Please refer to the General Exclusions section
-

Behavioral Health Mental Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Outpatient health care professional charges for services including: <ul style="list-style-type: none"> ○ Assessment and diagnostic services ○ Individual/group/family therapy (office/in-home mental health services) ○ Neuro-psychological examinations ▪ Professional health care charges for services including: <ul style="list-style-type: none"> ○ Clinical based partial programs ○ Clinical based day treatment ○ Clinical based Intensive Outpatient Programs (IOP) ▪ Outpatient hospital/outpatient behavioral health treatment facility charges for services including: <ul style="list-style-type: none"> ○ Evaluation and diagnostic services ○ Individual/group therapy ○ Crisis evaluations ○ Observation beds ○ Family therapy ▪ Inpatient health care professional charges ▪ Inpatient hospital and children’s residential behavioral health treatment facility charges for services including: <ul style="list-style-type: none"> ○ Hospital based partial programs ○ Hospital based day treatment 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> ○ Hospital based Intensive Outpatient Programs (IOP) ○ All eligible inpatient services ○ Emergency holds ○ Residential eating disorder treatment (also covered for adults) | | |
|---|--|--|

NOTES:

- Please refer to the Notification Requirements section.
- You may choose a mental health provider yourself. The 3M Employee Assistance Program (EAP) can help you choose a mental health provider. Contact the EAP professional serving your 3M location (at 3M Center call (651) 736-1375) or call the Employee Assistance Program at (877) 321-7252 (toll free). A 3M EAP professional can provide confidential personal consultation to you and work with you to find a provider for your situation. Personal consultation through 3M EAP is confidential and is provided at no charge to you.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary. A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity without further review by the Claims Administrator.
- Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds” as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- Coverage is provided for marriage/couples therapy when the covered member has a diagnosable mental health disorder, and the therapy is medically necessary to relieve the symptoms associated with the diagnosis.
- Coverage is provided for diagnosable mental health conditions, including eating disorders.
- Coverage provided for treatment of emotionally disabled children (available up to age 18) in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- For home health related services, please refer to Home Health Care section.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include emails and physician/patient telephone calls, except for eligible E-Visits.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.

NOT COVERED:

- Services for mental illness not listed in the most recent edition of the International Classification of Diseases
 - Residential behavioral health treatment facility charges for individuals 18 and over
 - Services for the treatment of learning disabilities and disorders
 - Educational testing
 - Compulsive gambling
 - Custodial care, nonskilled care, adult daycare or personal care attendants
 - Services of confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs
 - Room and board for foster care, group homes, incarceration, shelter care, and lodging programs
 - Halfway house services
 - Services for marriage/counseling therapy/counseling relationship improvement/enhancement services/training not related to the treatment of a covered member's diagnosable mental health disorder
 - Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
 - Educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
 - Skills training
 - Therapeutic support or foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
 - Therapeutic day care and therapeutic camp services
 - Hippotherapy (equine movement therapy)
 - Charges made by a health care professional for email and physician/patient telephone consultations, except for eligible E-Visits
 - Please refer to the General Exclusions section
-

Behavioral Health Substance Abuse Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Outpatient health care professional charges for services including: <ul style="list-style-type: none"> ○ Assessment and diagnostic services ○ Family therapy ○ Opioid treatment ▪ Outpatient hospital/outpatient behavioral health treatment facility charges for services including: <ul style="list-style-type: none"> ○ Intensive Outpatient Programs (IOP) and related aftercare services ▪ Inpatient health care professional charges ▪ Inpatient hospital/ residential (high intensity) chemical health treatment facility charges 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- You may choose a substance abuse provider yourself. The 3M Employee Assistance Program (EAP) can help you choose a substance abuse provider. Contact the EAP professional serving your 3M location (at 3M Center call (651) 736-1375) or call the 3M EAP at (877) 321-7252 (toll free). A 3M EAP professional can provide confidential personal consultation to you and work with you to find a provider for your situation. Personal consultation through 3M EAP is confidential and is provided at no charge to you.
- Court-ordered treatment for substance abuse care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified substance abuse assessor is deemed medically necessary.
- A court-ordered, initial exam for a dependent child under the age of 18 is also considered medically necessary without further review by the Claims Administrator.
- Court-ordered treatment for substance abuse care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity.
- Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.

- Admissions that qualify as “emergency holds”, as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- For home health related services, please refer to Home Health Care section.
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone calls, except for eligible E-Visits.

NOT COVERED:

- Services for substance abuse or addictions not listed in the most recent edition of the International Classification of Diseases
 - Custodial care, nonskilled care, adult daycare or personal care attendants
 - Residential behavioral health treatment facility charges
 - Services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to, the following: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs
 - Room and board for foster care, group homes (residential **low** intensity treatment), incarceration, shelter care, and lodging programs
 - Halfway house services (residential **low** intensity treatment)
 - Substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health or a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition
 - Charges made by a health care professional for email and physician/patient telephone consultations, except for eligible E-Visits
 - Please refer to the General Exclusions section
-

Biofeedback

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">▪ Biofeedback services when provided by a physician or a biofeedback therapist referred by a physician or a mental health professional that qualifies under this Plan	For the level of coverage, refer to Behavioral Health Mental Health Care, Behavioral Health Substance Abuse Care, Hospital Inpatient, and Hospital Outpatient.	For the level of coverage, refer to Behavioral Health Mental Health Care, Behavioral Health Substance Abuse Care, Hospital Inpatient, and Hospital Outpatient.

NOTES:

- Please refer to the Notification Requirements section.
- The Plan will pay biofeedback benefits based on where the treatment is provided and whether or not there is a mental health or substance abuse diagnosis. For biofeedback benefits without a mental health or substance abuse diagnosis, please refer to either Hospital Inpatient or to Hospital Outpatient. For biofeedback benefits with a mental health or substance abuse diagnosis please refer to Behavioral Health Mental Health Care or Behavioral Health Substance Abuse Care.

NOT COVERED:

- Biofeedback services not provided by a physician, or a biofeedback therapist referred by a physician or a mental health professional that qualifies under this Plan
 - Please refer to the General Exclusions section
-

Chiropractic Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Chiropractic care 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- The Plan will cover up to 25 visits per person per calendar year for all networks combined. Chiropractic services may also be denied prior to the 25 visit limit if continuation of the services is not considered medically necessary.
- The Plan will only cover neuromuscular skeletal conditions when receiving chiropractic services for rehabilitative care.
- The Plan covers cervical supports and lumbosacral supports when prescribed by a chiropractor.
- The Plan covers custom made removable arch supports one (1) pair per person per calendar year when prescribed by a chiropractor.
- The Plan covers massage therapy if it is performed in conjunction with a manipulation or therapy procedure.
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.

NOT COVERED:

- Supplies or durable medical equipment dispensed and billed by a chiropractor, except as specified in the Benefit Chart
 - Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
 - Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other non medical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs
 - Services for or related to therapeutic massage, except as specified in the Benefit Chart
 - Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy to treat the member's condition
 - Custodial care
 - Please refer to the General Exclusions section
-

Dental Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<p>This is not a dental plan. The following limited dental-related coverage is provided:</p> <ul style="list-style-type: none"> ▪ Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth ▪ Treatment of ectodermal dysplasia or cleft lip and palate when services are scheduled or initiated prior to the member turning 19 including: <ul style="list-style-type: none"> ○ Dental implants ○ Removal of impacted teeth or tooth extractions ○ Related oral surgery ○ Related orthodontia ○ Bone grafts ▪ Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: <ul style="list-style-type: none"> ○ Orthognathic surgery 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must be initiated within twelve months of the date of injury. Services must be provided within twenty-four months of the date of injury to be covered. Treatment of dependent children after the 24 month period may be covered if a medical or dental circumstance warrants a delay in completion of the treatment. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.

- The Plan covers anesthesia and inpatient and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dentist's bills and charges for anesthesia may be covered under the 3M Dental Plan.
- For hospital/facility charges, please refer to Hospital Inpatient or Hospital Outpatient.
- The Plan covers dental implants if they are medically necessary to restore a natural tooth to most closely approximate pre-accident form and function or with a cleft lip and palate diagnosis. The damage must be the result of an accidental injury to a sound and healthy natural tooth struck from outside the mouth. Eligible dental implant treatment related to an accident must be completed within 24 months of the accident.
- For medical services, please refer to Hospital Inpatient, Hospital Outpatient, Physician Services, etc.
- A sound and healthy natural tooth is a tooth that is functioning in the mouth that is organic and formed by natural development of the body (not artificial or manufactured), and is not predisposed to injury due to extensive restoration, disease, or decay.
- The Plan covers extraction of natural teeth prior to or after radiation therapy.
- The Plan covers appliances used to protect the teeth during radiation therapy, in lieu of extractions (i.e., fluoride tray).
- The Plan covers the excision of the lingual frenum (release of tongue-tied).

NOT COVERED:

- Dental services and dental implants for cracked or broken teeth, which result from biting or chewing
- Dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts, unless otherwise specified as covered
- Dental implants, except as specified in the Benefit Chart
- Removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as specified in the Benefit Chart
- CT scans or magnetic resonance imaging (MRI) except in conjunction with services for surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder
- Accident-related dental services received after 24 months from the date of injury
- Replacement of a damaged dental bridge from an accident-related injury
- Osteotomies and other procedures associated with the fitting of dentures
- All orthodontia, except as specified in the Benefit Chart
- Oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth, except as specified in the Benefit Chart
- Root canal therapy, unless an accident related injury
- Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
- Please refer to the General Exclusions section

Emergency Room

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">Outpatient hospital/facility emergency room charges	90% after you pay the deductible and emergency room facility copay.	90% after you pay the deductible and the emergency room facility copay.
<ul style="list-style-type: none">Outpatient health care professional charges	90% after you pay the deductible.	90% after you pay the deductible.

NOTES:

- Please refer to the Notification Requirements section.
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- For inpatient services, please refer to Hospital Inpatient and Physician Services.
- For urgent care visits, please refer to Hospital Outpatient and Physician Services.
- The emergency room facility copay is waived if you are admitted within 24 hours.

NOT COVERED:

- Please refer to the General Exclusions section
-

Gender Identity Disorder Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Inpatient hospital/facility charges for medical and surgical treatment of Gender Identity Disorder including: <ul style="list-style-type: none"> ○ Semiprivate room and board and general nursing care (private room is covered only when medically necessary) ○ Intensive care and other special care units ○ Operating, recovery, and treatment rooms ○ Anesthesia ○ Prescription drugs and supplies used during a covered hospital stay ○ Lab and diagnostic imaging 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> ▪ Outpatient hospital/facility charges for medical and surgical treatment of Gender Identity Disorder including: <ul style="list-style-type: none"> ○ Scheduled surgery/anesthesia ○ Lab and diagnostic imaging ○ All other outpatient hospital care 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> ▪ Health care professional charges for medical and surgical treatment of Gender Identity Disorder including: <ul style="list-style-type: none"> ○ Office visit ○ Urgent Care outpatient professional visit ○ E-Visit ○ Lab and diagnostic imaging ○ Inpatient lab and diagnostic imaging ○ Inpatient hospital/facility visits during a covered 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

admission <ul style="list-style-type: none"> ○ Outpatient hospital/facility visits ○ Anesthesia by a provider other than the operating or assisting provider ○ Surgery ○ Assistant surgeon ○ Injectable drugs administered by a health care professional 		
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NOTES:

- Prior authorization is required for Gender Identity Disorder services. Please refer to the Notification Requirements section.
- Gender Identity Disorder is a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. Sex reassignment refers to the process through which an individual diagnosed with Gender Identity Disorder seeks to change his/her biological body through hormonal therapy, sex transformation surgery or both.
- Sex transformation surgery (genital and breast reconstruction surgery) for the treatment of Gender Identity Disorder is a covered benefit under this Plan. All other eligible medically necessary surgical services for the treatment of Gender Identity Disorder are limited to a lifetime maximum benefit of \$75,000 per person.
- All requests for prior authorization must be submitted in writing to:
 HealthPartners
 Medical Policy Department, Mail Stop 21108T
 P.O. Box 1309
 Minneapolis, MN 55440-1309
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. The Plan does not cover a charge separate from the surgery for pre- and post-operative care.
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the physician's time.
- E-Visit is an online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.

NOT COVERED:

- Repair of scars and blemishes on skin surfaces
- Separate charges for pre-operative and post-operative care for surgery
- Internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit

- Cosmetic surgery to repair a physical defect
 - Treatment, services or supplies which are not medically necessary
 - Please refer to the General Exclusions section
-

Home Health Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to: <ul style="list-style-type: none"> ○ Intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> • Licensed practical nurse • Medical technologist • Licensed registered dietician • Respiratory therapist ○ Physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ○ Services of a home health aide or masters level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ○ Use of appliances that are owned or rented by the home health agency ○ Home health care following early maternity discharge ○ Palliative care 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- The Plan will cover up to eight (8) visits for palliative care per person per calendar year for all networks combined. Palliative care services may be reviewed for medical necessity and continued coverage may be approved or denied even before you reach the eight (8) visit limit.

- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

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

Home Infusion Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Home infusion therapy services when ordered by a physician ▪ Solutions and pharmaceutical additives, pharmacy compounding and dispensing services ▪ Durable medical equipment ▪ Ancillary medical supplies ▪ Nursing services to: <ul style="list-style-type: none"> ○ Train you or your caregiver ○ Monitor your home infusion therapy ▪ Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy ▪ Other eligible home health services and supplies provided during the course of home infusion therapy 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.

NOT COVERED:

- Home infusion services or supplies not specifically listed as covered services
- Nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- Services that do not involve direct patient contact, such as delivery charges and recordkeeping
- Please refer to the General Exclusions section

Hospice Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice, including: <ul style="list-style-type: none"> ○ Routine home care ○ Continuous home care ○ Inpatient respite care ○ General inpatient care 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please see the Notification Requirements section.
- Prior approval is required for entrance into the hospice benefit, for any inpatient admission while the patient is receiving hospice benefits, for any patient living beyond six (6) months, and for determination of coverage for services unrelated to the terminal condition.
- Benefits are restricted to terminally ill patients with a terminal condition (i.e., life expectancy of six (6) months or less). The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- Hospice is generally covered subject to the indications listed below and is paid on a fee for service basis only. To be eligible for Hospice members must:
 - Be terminally ill (life expectancy of six months or less).
 - Have chosen a plan of care focused on comfort and supportive service (palliative) and not curative care.
 - Elect to receive services primarily in the home.
 - Be accepted by a Hospice program as a participant and have signed the hospice election form.
- Indications that are covered:
 - Providers must be Medicare certified. Care must be provided in accordance with an approved Hospice treatment plan as directed by the PCP (primary care physician) or designee.
 - Part-time care (the visit is 0 to 2 hours) provided in the member's home by an interdisciplinary hospice team, which may include a physician, nurse, social worker, PT, OT or speech therapist, home health aide or spiritual counselor and medically necessary home health services.
 - Continuous Care/Respite Care (over 2 hours per day) - a HealthPartners Medical Director or his or her designee will provide symptom management or respite care. Combined coverage is limited to 30 days; respite care is limited to 5 days per episode and prior approval is required.
 - Inpatient Services for Acute Care - Medically necessary inpatient services when authorized by the HealthPartners Medical Director or his or her designee.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

- Custodial or non-skilled care
 - Room and board expenses in a residential hospice facility
 - Please refer to the General Exclusions section
-

Hospital Inpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Semiprivate room and board and general nursing care (private room is covered only when medically necessary) ▪ Intensive care and other special care units ▪ Operating, recovery, and treatment rooms ▪ Anesthesia ▪ Prescription drugs and supplies used during a covered hospital stay ▪ Lab and diagnostic imaging ▪ Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major organ transplant or other kinds of transplants, please refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
 - Potential donor testing
 - Donor evaluation and work-up; and
 - Hospital and professional services related to organ procurement
- The Plan covers anesthesia and inpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- For gender identity disorder treatment and related services, please refer to Gender Identity Disorder Treatment.

NOT COVERED:

- Communication services provided on an outpatient basis or in the home
- Travel expenses for a kidney donor

- Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
 - Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
 - Please refer to the General Exclusions section
-

Hospital Outpatient

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Scheduled surgery/anesthesia ▪ Radiation and chemotherapy ▪ Kidney dialysis ▪ Respiratory therapy ▪ Physical, occupational, speech, and vision therapy ▪ Lab and diagnostic imaging ▪ Diabetes outpatient self-management training and education, including medical nutrition therapy ▪ Palliative care ▪ All other outpatient hospital care 	90% after you pay the deductible.	90% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> ▪ Urgent care 	90% after you pay the deductible.	90% after you pay the In-Network deductible.

NOTES:

- Please refer to the Notification Requirements section.
- The Plan covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of a progressive, debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers massage therapy if it is performed in conjunction with a manipulation or therapy procedure.
- Eligible urgent care services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- For gender identity disorder treatment and related services, please refer to Gender Identity Disorder Treatment.

NOT COVERED:

- Please refer to the General Exclusions section
-

Infertility Treatment

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Diagnosis and treatment of conditions that cause infertility 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- Benefits for injectable prescription drugs when used to diagnose or treat anovulation, ovarian dysfunction, or unexplained infertility in women. Injectable infertility drugs are limited to six (6) cycles per person per lifetime, or per pregnancy. The six (6)-cycle limit will be renewed if successful pregnancy is attained. Pregnancy must be confirmed by a live birth, an ultrasound, or by a miscarriage documented by a pathology report.
- Any cycle billed to the Claims Administrator for injectable prescription drugs will be applied to the six (6)-cycle maximum. If the patient abandons a treatment regimen before the cycle is complete, the partial cycle may be counted as one of the six (6) eligible cycles or the patient may assume all charges for that cycle in order to preserve benefits for six (6) complete cycles.
- A cycle is defined as one (1) partial or complete fertilization attempt extending through the implantation phase only.
- Chorionic gonadotropin are not applied towards the six (6) cycle limit.
- For hospital/facility charges, please refer to Hospital Inpatient and Hospital Outpatient.

NOT COVERED:

- Assisted reproductive technologies, such as artificial insemination, in vitro fertilization, gamete intrafallopian transfer (G.I.F.T.) and related expenses
- Egg fertilization or cell transfer (part of the in vitro fertilization procedure)
- IUI (intrauterine insemination)
- Laparoscopy for egg retrieval (part of the in vitro fertilization procedure)
- Ovustick urine kit
- Semen/sperm separation
- Semen swimup
- Sperm incubation
- Sperm washing
- Wool spin or filtering
- Cryopreservation
 - Freezing, thawing, storage
- Ultrasound guided retrieval
- Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services
- Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm, ova, embryos, stem cells, cord blood, and any other human tissue, except as specified in the Benefit Chart
- Please refer to the General Exclusions section

Maternity

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Health care professional services and hospital/facility charges for prenatal care, except for services included under Preventive Care ▪ Health care professional services for: <ul style="list-style-type: none"> ○ Delivery in a hospital/facility ○ Postpartum care ▪ Inpatient hospital/facility services for inpatient hospital care ▪ Outpatient hospital/facility services for outpatient hospital care 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- Please refer to the Eligibility section to determine when baby's coverage will begin.
- Group health plans such as this Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may under federal law, require that a provider obtain authorization from the Claims Administrator for prescribing a length of stay greater than 48 hours (or 96 hours).
- The Plan covers one (1) home health care visit within four (4) days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See Home Health Care section.

NOT COVERED:

- Health care professional charges for deliveries in the home
- Services for or related to adoption fees
- Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services

- Child-birth classes
 - Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm, ova, embryos, stem cells, cord blood, and any other human tissue, except as specified in the Benefit Chart
 - Please refer to the General Exclusions section
-

Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds ▪ Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings ▪ Insulin pumps, glucometers and related equipment and devices ▪ Blood, blood plasma, and blood clotting factors ▪ Ostomy supplies ▪ Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes ▪ Mastectomy bra, limited to four (4) mastectomy bras per person for the first year following surgery and three (3) mastectomy bras per person per calendar year for all subsequent years ▪ Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician ▪ Corrective lenses for aphakia ▪ Non-investigative bone conductive hearing devices ▪ Amino acid-based elemental formula for patients with the following conditions: 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

<ul style="list-style-type: none"> ○ Cystic fibrosis ○ Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders ○ IgE-mediated allergies to food proteins, limited to patients five (5) years of age and under ○ Food protein-induced enterocolitis syndrome ○ Eosinophilic esophagitis ○ Eosinophilic gastroenteritis ○ Eosinophilic colitis 		
<ul style="list-style-type: none"> ▪ Hearing aids, batteries, repairs, fittings and adjustments to a maximum benefit of \$750 per person per ear, every three (3) years 	100%	100%

NOTES:

- Please refer to the Notification Requirements section.
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- The Plan will cover services for or related to custom foot inserts including purchase and repair when prescribed by a physician. Replacements are covered as needed to treat a condition for wear and tear if not repairable or if the condition has changed.
- The Plan will cover custom orthopedic shoes when prescribed by a physician according to medical policy guidelines.
- The Plan will cover alteration of one (1) pair of orthopedic shoes when prescribed by a physician each year, the Plan will cover alterations of up to two (2) pairs of shoes each year up to the covered person's 2nd birthday.
- The Plan will cover one (1) pair of custom made removable arch supports per person per calendar year.
- The Plan will cover initial purchase of eyeglasses, contact lenses, or insertion of intraocular lenses required as the result of cataract surgery performed while covered under this Plan.
- The Plan will cover initial purchase of keratoconus lenses or the purchase of subsequent keratoconus lenses only when the physician provides a written statement verifying that there has been a change in the prescription.
- The Plan covers cervical supports, lumbrosacral supports, and custom made removable arch supports when prescribed by a chiropractor.

- For coverage of insulin and diabetic supplies, please refer to the Special Benefits Features section.
- Rental of an electric breast pump is eligible for coverage only when there is maternal-infant separation due to illness, prematurity, or hospitalization and only for the duration of the separation.
- Medications that are prescribed by your provider to manage PKU must be obtained through CVS/Caremark. PKU dietary supplements as defined by HealthPartners' coverage policy must be purchased through a DME vendor.

NOT COVERED:

- Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart
 - Personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary
 - Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants
 - Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
 - Blood pressure monitoring devices
 - Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
 - Services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart and in the Special Benefits Features section
 - Duplicate equipment, prosthetics, or supplies
 - Scalp hair prosthesis (wigs)
 - Supplies or durable medical equipment dispensed and billed by a chiropractor, except as specified in the Benefit Chart
 - Non-prescription supplies such as alcohol, cotton balls and alcohol swabs
 - Rental or purchase of manual breast pump and/or the purchase of an electric breast pump, except as specified in the Benefit Chart
 - Please refer to the General Exclusions section
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Physical Therapy, Occupational Therapy, Speech Therapy, Vision Therapy

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Office visits from a physical therapist, occupational therapist, speech therapist or language pathologist or vision therapist ▪ Therapies from a physical therapist, occupational therapist, speech therapist or language pathologist or vision therapist 	90% after you pay the deductible.	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> ▪ Office visits from a physician 	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

NOTES:

- Please refer to the Notification Requirements section.
- For lab and diagnostic imaging services billed by a health care professional, please refer to Physician Services.
- The Plan covers massage therapy if it is performed in conjunction with a manipulation or therapy procedure.
- For hospital/facility charges, please refer to Hospital Inpatient and Hospital Outpatient.

NOT COVERED:

- Services primarily educational in nature, except as specified in the Benefit Chart
- Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs
- Services for or related to therapeutic massage, except as specified in the Benefit Chart

- Physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
 - Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable amount of time, unless they are medically necessary and are part of specialized maintenance therapy for the member's condition
 - Custodial care
 - Please refer to the General Exclusions section
-

Physician Services

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Office visits for illness ▪ E-Visit ▪ Retail health clinic visit ▪ Lab and diagnostic imaging ▪ Allergy testing, serum, and injections ▪ Diabetes outpatient self-management training and education, including medical nutrition therapy ▪ Nutritional counseling services for diabetes, eating disorders, cardiac rehabilitation and weight reduction surgeries ▪ Inpatient hospital/facility visits during a covered admission ▪ Outpatient hospital/facility visits ▪ Anesthesia by a provider other than the operating, delivering, or assisting provider ▪ Surgery, including circumcision and sterilization ▪ Assistant surgeon ▪ Kidney and cornea transplants ▪ Injectable drugs administered by a health care professional ▪ Palliative care 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

<ul style="list-style-type: none"> ▪ Bariatric surgery to correct morbid obesity including; <ul style="list-style-type: none"> ○ Anesthesia ○ Assistant surgeon 		
<ul style="list-style-type: none"> ▪ Urgent care 	90% after you pay the deductible.	90% after you pay the In-Network deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the allowed amount for each procedure. When using a Nonparticipating Provider the allowed amount for more than one (1) procedure will be significantly reduced and you will be billed the difference between the charged amount and the allowed amount for more than one procedure. The reduction is due to the non-duplication of facility charges and the efficiencies of having one or more procedures completed at the same time.
- The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- The Plan covers charges for consultations performed on the telephone between the physician and the patient.
- The Plan covers certain physician services for preventive care. Please refer to Preventive Care.
- For kidney transplants performed in conjunction with an eligible major transplant. Please refer to Transplant Coverage.
- Office visits include medical history, medical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and the physician’s time.
- The Plan covers the following kidney donor services when billed under the donor recipient’s name and the donor recipient is covered for the kidney transplant under the Plan:
 - Potential donor testing
 - Donor evaluation and work-up; and
 - Hospital and professional services related to organ procurement
- E-Visit is an online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member’s life expectancy to two (2) years or less. The services must be within the scope of the provider’s license to be covered. Palliative care does not include hospice or respite care.
- Eligible urgent care services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- For gender identity disorder treatment and related services, please refer to Gender Identity Disorder Treatment.

NOT COVERED:

- Repair of scars and blemishes on skin surfaces
 - Separate charges for pre-operative and post-operative care for surgery
 - Internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit
 - Cosmetic surgery to repair a physical defect
 - Travel expenses for a kidney donor
 - Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
 - Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
 - Please refer to the General Exclusions section
-

Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Professional and outpatient hospital/facility preventive care services include recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) for: <ul style="list-style-type: none"> ○ Adults ○ Infants and children ▪ Cancer screening as specified below: <ul style="list-style-type: none"> ○ Mammograms ○ Pap smears ○ Flexible sigmoidoscopies and/or screening fiberoptic colonoscopies ○ Fecal occult blood testing ○ Prostate Specific Antigen (PSA) tests, digital rectal exams ○ Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam) ▪ Preventive medical evaluation ▪ Gynecological exam ▪ Hearing screening, one (1) per calendar year ▪ Immunizations 	<p>100%</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

<ul style="list-style-type: none"> ▪ Diagnostic imaging services as specified below: <ul style="list-style-type: none"> ○ Osteoporosis screening (radiology services) ○ Abdominal Aortic Aneurysm (AAA) ultrasound screening 		
<ul style="list-style-type: none"> ▪ Lab services as specified below: <ul style="list-style-type: none"> ○ Lipid profile, including total cholesterol and HDL cholesterol ○ Thyroid screening ○ Diabetes screening ○ Hemoglobin-CBC ○ Urinalysis ○ Screening for chlamydia, gonorrhea, syphilis and HIV 	100%	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- Preventive care services comply with federal statutes and regulations (i.e., cancer screening services).
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Please refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- For hospital/facility charges, please refer to Hospital Outpatient.

NOT COVERED:

- Services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- Preventive vision exams , except where eligible in the Special Benefits Features section
- Services for or related to preventive medical evaluations for the purpose of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical exam would normally have been provided in the absence of the third party request
- Educational classes or programs
- Services for or related to lenses, frames, and contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except where eligible under Medical Equipment, Prosthetics, and Supplies and in the Special Benefits Features section
- Treatment services or supplies which are investigative or not medically necessary
- Please refer to the General Exclusions section

Reconstructive Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part must be performed within 24 months of an accident or previous surgery for the condition or first day of coverage or before age 19 ▪ Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician to age 19 ▪ Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including dental implants ▪ Elimination or maximum feasible treatment of port wine stains 	<p>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>	<p>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>

NOTES:

- Please see the Notification Requirements section.
- Under the Federal Women’s Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- For gender identity disorder treatment and related services, please refer to Gender Identity Disorder Treatment.

NOT COVERED:

- Repair of scars and blemishes on skin surfaces
 - Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts
 - Please refer to the General Exclusions section
-

Skilled Nursing Facility

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> ▪ Skilled care ordered by a physician and eligible under Medicare guidelines ▪ Semiprivate room and board ▪ General nursing care ▪ Prescription drugs used during a covered admission ▪ Physical, occupational, speech, and vision therapy 	<p>90% after you pay the deductible.</p>	<p>65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.</p>

NOTES:

- Please refer to the Notification Requirements section.
- Coverage is limited to a maximum benefit of 90 days per person per confinement.
- You must be admitted within 30 days after hospital admission of at least three (3) consecutive days for the same illness.
- Successive periods of all skilled nursing facility confinements are considered one (1) period of confinement unless the dates of discharge and readmission are separated by at least 14 days.

NOT COVERED:

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

Transplant Coverage

The Plan Covers:	Designated Transplant Center (DTC)	Non-Designated Transplant Center (Non-DTC)
<p>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> ▪ Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures ▪ Autologous bone marrow transplant and peripheral stem cell transplant procedures ▪ Heart ▪ Heart-lung ▪ Kidney-pancreas transplant performed simultaneously (SPK) ▪ Liver - deceased donor and living donor ▪ Lung - single or double ▪ Pancreas transplant - deceased donor and living donor segmental <ul style="list-style-type: none"> ○ Pancreas transplant alone (PTA) ○ Simultaneous pancreas-kidney transplant (SPK) ○ Pancreas transplant after kidney transplant (PAK) ▪ Small-bowel and small-bowel/liver 	<p>100% of the Transplant Payment Allowance for the transplant admission.</p> <p>If you live more than 50 miles from a DTC Provider, there may be travel reimbursement available for expenses directly related to a preauthorized transplant. See NOTES.</p>	<p>Non Participating Transplant Provider</p> <p>NO COVERAGE. YOU WILL BE RESPONSIBLE FOR ALL COSTS.</p> <p>Nonparticipating Transplant Provider</p> <p>NO COVERAGE. YOU WILL BE RESPONSIBLE FOR ALL COSTS.</p>

NOTES:

- Kidney transplants when not performed in conjunction with an eligible major organ transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to Hospital Inpatient and Physician Services.
- Travel reimbursement when you travel more than 50 miles to obtain transplant care at a DTC or when the DTC provider requires you to stay at or nearby the transplant facility.
 - Coverage for eligible travel benefits is 100%.
 - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility. The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the

dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the DTC only.

- Total benefit shall not exceed \$10,000 per lifetime.
- Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
- Reimbursed expenses are not tax deductible. Consult your tax advisor.

NOT COVERED:

- Services for or related to preservation storage and thawing of human tissue including, but not limited to: sperm, ova, embryos, stem cells, cord blood, and any other human tissue, except as specified in the Benefit Chart
- Travel benefits when you are using a Non-DTC Provider
- Services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- Services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- Living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description
- Transplantation of animal organs and/or tissue
- Non-covered travel expenses include but are not limited to: utilities; child care; pet care; security deposits; cable hook-up; dry cleaning; laundry; car rental; and personal items
- Travel lodging is not eligible when staying with family or friends
- Travel lodging for a companion/caregiver
- Services you receive from a Nonparticipating Provider
- Please refer to the General Exclusions section

DEFINITIONS:

- DTC Provider means a hospital or other institution that has a contract to provide human organ or bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.

Description	Benefit
Patient	<i>Up to \$50 per day for lodging and meals purchased at the transplant facility.</i>
Transportation	Applies to patient traveling to and from home or local housing and the transplant facility.
	Includes: a) Travel by car (includes rental) b) Parking fees and tolls c) Public transportation (bus, taxi, train, plane)
	Car mileage reimbursement rate is the IRS medical mileage allowance in effect on the dates of travel.
Benefit maximum	Shall not exceed \$10,000 per lifetime.

Description	Benefit
Benefit eligibility	<p>When traveling more than 50 miles to obtain care at a DTC or when the DTC requires you to stay at or nearby the facility.</p> <p>Applies to all transplant care obtained at the DTC – for purposes of evaluation, the transplant procedure, and all post-discharge follow-up.</p>
Lodging eligibility	Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities. It is not eligible is staying with family or friends.
Taxes	Reimbursed expenses are not tax deductible. Consult your tax advisor.
Exclusions	Non-covered expenses include, but are not limited to: utilities, child care, security deposits, cable hook-up, dry cleaning, laundry, car rental, pet care and personal items.
Procedure for Claims Submission	<ol style="list-style-type: none"> 1. Complete the Transplant Travel Benefit Reimbursement Request Form. 2. Attach all applicable lodging, meal, or transportation receipts. 3. Mail to address listed on claim form.
Timely Claim Filing	Travel benefit claims must be submitted in accordance with the Plan’s timely filing requirements.
Questions	Member Services at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free).

Well-Child Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none">▪ The following services for a dependent child from birth to age 18:<ul style="list-style-type: none">○ Preventive services○ Developmental assessments○ Laboratory services○ Immunizations	100%	65% after you pay the deductible, plus you pay any charges billed to you that exceed the allowed amount.

NOTES:

- Please refer to the Notification Requirements section.
- For hospital/facility charges, please refer to Hospital Outpatient.

NOT COVERED:

- Please refer to the General Exclusions section
-

General Exclusions

The Plan does not pay for:

1. Treatments, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative.
3. Charges for or related to care that is custodial or not normally provided as preventive care or treatment of an illness.
4. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.
5. Services that are normally provided without charge, including services of the clergy.
6. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while your coverage was in force.
7. Services for or related to therapeutic acupuncture, except as specified in the Benefit Chart.
8. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim, unless the workers' compensation carrier has disputed the claim.
9. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
10. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent and/or child).
11. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony the Plan Manager has determined occurred.
12. Services to treat illness/injuries which occur while on military duty that are recognized by the Veterans Administration as services related to service-connected illnesses/injuries.
13. Services for dependents if you have employee-only coverage or for ineligible dependents.
14. Services that are prohibited by law or regulation.
15. Services which are not within the scope of licensure or certification of a provider.
16. Diagnostic studies, except when required by existing symptoms of an illness.
17. Charges for furnishing medical records or reports and associated delivery charges.

18. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the Benefit Chart.
19. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.
20. Services for or related to mental illness not listed in the most recent edition of the *International Classification of Diseases*.
21. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.
22. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations, parenting assessment, education classes, classes for Driving Under the Influence (DUI) and/or Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.
23. Services for or related to room and board for foster care, group homes, incarceration, shelter care and lodging programs, halfway house services, and skills training.
24. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.
25. Services for or related to marriage/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder.
26. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).
27. Services for or related to treatment of compulsive gambling or other lifestyle changes.
28. Charges made by a health professional for televideo conferencing services, email and physician/patient telephone consultations, except for eligible E-Visits and as specified in the Benefit Chart.
29. Services for or related to substance abuse or addictions not listed in the most recent edition of the *International Classification of Diseases*.
30. Services for or related to substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition.
31. Services for or related to therapeutic massage, except as specified in the Benefit Chart.
32. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts, except as specified in the Benefit Chart.

33. Services for or related to the replacement of a damaged dental bridge from an accident-related injury.
34. Services for or related to oral surgery and anesthesia for the removal of impacted teeth, except as specified in the Benefit Chart.
35. Services for or related to oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy.
36. Services for or related to dental or oral care, treatment, orthodontics, or surgery and any related supplies, anesthesia or facility charges, except as specified in the Benefit Chart.
37. Room and board expenses in a residential hospice facility.
38. Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by the Claims Administrator as medically necessary.
39. Admission for diagnostic tests that can be performed on an outpatient basis.
40. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as specified in the Benefit Chart.
41. Personal comfort items, such as telephone, television, barber and beauty supplies, guest services, etc.
42. Communication services provided on an outpatient basis or in the home.
43. Services for or related to gender selection.
44. Services and prescription drugs for or related to reproduction treatment including, assisted reproductive technology (ART), artificial insemination (AI), and intrauterine insemination (IUI) procedures.
45. Services for or related to reversal of sterilization.
46. Services for or related to adoption fees and childbirth classes.
47. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.
48. Donor ova or sperm.
49. Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm, ova, embryos, stem cells, cord blood, and any other human tissue, except as specified in the Benefit Chart.
50. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart.
51. Services or supplies that are primarily and customarily used for nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not

limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants.

52. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.
53. Blood pressure monitoring devices.
54. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
55. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.
56. Services for or related to preventive vision exams. Refer to the Special Benefit Features section for coverage.
57. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
58. Services primarily educational in nature, except as specified in the Benefit Chart.
59. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.
60. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.
61. Services for or related to health clubs and spas.
62. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the member's condition.
63. Custodial care.
64. Services for or related to recreational therapy (defined as the prescribed use of recreation and other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages) or educational therapy (defined as special education classes, tutoring, and other non medical services normally provided in an educational setting), or forms of nonmedical self care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
65. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
66. Services for or related to the repair of scars and blemishes on skin surfaces.

67. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
68. Services for or related to cosmetic health services or reconstructive surgery and related services and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart or for procedures determined to be medically necessary with a gender identity disorder diagnosis.
69. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.
70. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment: services for or related to homeopathy, or chelation therapy that the Claims Administrator determines is not medically necessary.
71. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
72. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.
73. Autopsies.
74. Charges for failure to keep scheduled visits.
75. Charges for giving injections which can be self-administered.
76. Internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit.
77. Services for or related to smoking cessation program fees and/or related program supplies, except as specified in the Special Benefit Features sections.
78. Charges for over-the-counter drugs except as specified in the Benefit Chart; vitamin or dietary supplements; and investigative or non-FDA approved drugs. Refer to the Special Benefit Features section for coverage information.
79. Smoking cessation drugs without a prescription or documented enrollment in the stop-smoking program.
80. Outpatient prescription drugs whether purchased through mail order or a retail pharmacy, refer to the Special Benefit Features section for coverage information.
81. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

82. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
83. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.
84. Services for or related to fetal tissue transplantation.
85. Health 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. However, if a court orders an examination for a child, the initial examination will be covered. Court ordered treatment for behavioral health services will be covered consistent with the Claims Administrator's medical coverage criteria (available on-line at www.healthpartners.com or by calling Member Services at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free)).

Special Benefit Features

3M has routine vision and prescription drug coverage which are special benefit features that are NOT covered by Health Partners. The routine vision benefit is administered through Vision Service Plan (VSP) and prescription drug coverage is administered by CVS/Caremark.

Routine Vision Feature

If you are enrolled in the Plan, you are eligible for routine vision care through Vision Service Plan (VSP).

How the Routine Vision Feature Works

Under the VSP routine vision program, there is no need for a separate benefit card. A thorough eye examination is provided, which can uncover the presence of a disease that you may not be aware you have. Symptoms of diabetic retinopathy, macular degeneration, glaucoma, and many other eye diseases and potentially serious health problems can be found when an Optometrist or Ophthalmologist looks at the cornea and blood flow to the retina during an eye exam. Just locate a VSP doctor, and identify yourself as a VSP member when you make your appointment. The doctor's office will check your eligibility for you.

To find a VSP doctor in your area:

- Call your doctor's office and ask if they participate in VSP;
- Visit the VSP website made especially for 3M at www.vsp.com/3M; or
- Call the VSP Customer Service number at (800) 877-7195 (toll free).

You are eligible for the following benefits when you use a VSP doctor:

- One complete eye examination per calendar year. You pay a \$15 copay, then the plan pays 100%.
- One frame and pair of prescription lenses every two calendar years. You pay a \$40 copay, then the plan covers plastic or glass single vision, lined bifocal, lined trifocal or lenticular lenses at 100%. Frames are covered up to a \$115 allowance. If frame exceeds the allowance, the difference is discounted by 20% and you pay the balance. Children under 18 may receive a pair of lenses once every calendar year with a \$40 copay. Children under the age of 21 are covered 100% for polycarbonate lenses.
- You may choose contact lenses instead of the frame/lens combination. The plan pays 100% up to an allowance of \$105 in total charges once every two calendar years. Your allowance is applied to both the contact lens exam (fitting and evaluation) and the contact lenses. You pay the balance if the contact lens exam and contact lens materials exceed \$105 allowance. The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating your vision with the contacts.
- Contact lenses that are medically necessary are covered in full after your \$40 copay if required for certain medical conditions that prevent you from wearing eyeglasses. Medically necessary contacts must be pre-approved by VSP, and are covered once every two calendar years.
- If you choose to purchase additional pairs of prescription eyeglasses after your covered pair of eyeglasses or contacts, you will benefit from a 30% discount from the same VSP doctor on the same day as your covered eye exam or 20% discount from any VSP doctor within 12 months of receiving your last covered eye exam.

Because your VSP benefits are designed to protect your visual wellness, you may have to pay extra if you choose certain cosmetic or elective eyewear options. Before selecting your eyewear, ask your doctor what is fully covered by your VSP plan.

If you choose to visit an out-of-network provider:

- VSP will reimburse you up to the maximum out-of-network rates. You will need to pay the entire cost at the time of your visit, and then submit a detailed bill to VSP for reimbursement. No special claim forms are necessary. Please note that you will likely be charged full retail prices, and that your out-of-network reimbursement rate does not guarantee full payment of provider charges. Refer to your VSP materials, the VSP website for 3M, or the VSP Customer Service line for further information and filing instructions for out-of-network benefits.
- Claims for benefits under VSP, and appeal of claims decisions, are processed pursuant to the procedures applicable to post-service claims, described in the section “Claims Procedures”. However, claims and appeals decisions for VSP claims are made by Vision Service Plan, which is the Claims Administrator for the VSP program.

Please note: Claims for out-of-network care must be received by VSP within 6 months of seeing the provider to be eligible for payment.

Prescription Drug Feature

If you are enrolled in the Plan, you are eligible for the prescription drug program through CVS/Caremark.

How the Prescription Drug Feature Works

You will receive a prescription drug card that you must show at participating pharmacies. Here is how you buy covered prescription drugs at a participating pharmacy under the Plan:

- You present your 3M prescription drug card to the participating pharmacy when you need a prescription filled. You pay the pharmacy only the amount of your coinsurance or copay (see table below). The pharmacy will then file a claim with CVS/Caremark for the balance. You pay no deductibles, and you have no claim forms to file.
- There is a \$ 1,100 individual/\$ 2,200 family out-of-pocket maximum. This means that once your out-of-pocket costs have reached the maximum, the Plan pays 100% of eligible prescription expenses for the rest of the year.
- If you purchase prescription drugs at a non-participating pharmacy, you will pay the full cost of the drug (not the discounted CVS/Caremark network price), and you must file a claim with CVS/Caremark for reimbursement. Pharmacies located outside of the United States will be considered non-participating pharmacies and claims will be reimbursed at the out-of-network benefit level (excluding 3M employees that are on a Foreign Service assignment).

NOTE: Specialty medications (including infertility) are only dispensed through Caremark home delivery. For questions, call (800) 700-5257 (toll free).

The portion of prescription drug cost you pay under the Plan is shown below:

Drug Status	Retail Pharmacy (up to a 30 day supply) ¹ Maximum of 2 fills		Retail Pharmacy 3 rd and subsequent fills		Home Delivery (up to a 90 day supply)
	In-Network	Out-of- Network	In-Network	Out-of- Network	
Generic	15%	35%	15% plus \$10 retail maintenance drug penalty ⁴	35% plus \$10 retail maintenance drug penalty ⁴	15%
Preferred Brand Name Drugs²	20% or minimum copay of \$20, whichever is greater ³ plus the difference between brand- name and generic cost (if generic is available) ⁵	40% or minimum copay of \$20, whichever is greater ³ plus the difference between brand- name and generic cost (if generic is available) ⁵	20% or minimum copay of \$20, whichever is greater ³ plus \$35 retail maintenance drug penalty ⁴ plus the difference between brand- name and generic cost (if generic is available) ⁵	40% or minimum copay of \$20, whichever is greater ³ plus \$35 retail maintenance drug penalty ⁴ plus the difference between brand- name and generic cost (if generic is available) ⁵	20% or minimum copay of \$40, whichever is greater ³ plus the difference between brand-name and generic cost (if generic is available) ⁵
Non- preferred Brand Name Drugs	30% or minimum copay of \$35, whichever is greater ³ plus the difference between brand- name and generic cost (if generic is available) ⁵	50% or minimum copay of \$35, whichever is greater ³ plus the difference between brand- name and generic cost (if generic is available) ⁵	30% or minimum copay of \$35, whichever is greater ³ plus \$50 retail maintenance drug penalty ⁴ plus the difference between brand- name and generic cost (if generic is available) ⁵	50% or minimum copay of \$35, whichever is greater ³ plus \$50 retail maintenance drug penalty ⁴ plus the difference between brand- name and generic cost (if generic is available) ⁵	30% or minimum copay of \$70, whichever is greater ³ plus the difference between brand-name and generic cost (if generic is available) ⁵

¹VA prescriptions may be eligible for up to 90-day supply at retail pharmacies. Please review SPD for further details.

²Preferred drugs for 3M participants are included on the CVS/Caremark Performance Drug List. Some “other” brand medications belonging in therapeutic classes NOT on the preferred drug list will fall into this category. Generally, no alternative treatments exist for these medications.

³You will pay the greater of either the coinsurance amount or the minimum copay. If the total cost of the medication is less than the minimum copay, you will pay the total cost of the medication.

⁴The retail maintenance drug penalty amount does not count toward the out-of-pocket maximum; you will pay this penalty even after you have met the out-of-pocket maximum.

⁵*This amount does not count toward the out-of-pocket maximum; you will pay this amount even after you have met the out-of-pocket maximum.*

Brand Name versus Generic Medications

When you bring a prescription to a participating pharmacy, the pharmacist will inform you if a generic equivalent is available. You, or your doctor who prescribed the medication, will have the choice of whether to choose the brand name medication or its generic equivalent. If a brand drug is necessary, your physician should write “dispense as written” on the prescription. You will still pay the difference between the generic and the brand name medication in addition to the copay and coinsurance, and this additional amount will not apply towards your prescription drug out-of-pocket maximum. You will be required to pay this difference even if you meet the annual out-of-pocket maximum.

As part of the generic drug requirement programs, you will be asked to try a generic drug in place of a brand-name drug in the treatment of high blood pressure, osteoporosis, high cholesterol, allergies (nasal steroids only), pain associated with joint inflammation (non-steroidal anti-inflammatory drugs), depression, urinary incontinence or stomach acid. If you are prescribed a new medication, ask your doctor to write the prescription for a generic drug first. If you choose to take a brand drug, without trying the generic first, your prescription will not be covered by the Plan and you will pay 100 percent of the cost every time you purchase it, which will not apply towards your prescription drug out-of-pocket maximum. You will continue to pay 100 percent of the cost even after you meet your out-of-pocket maximum.

If you use the home delivery program or purchase your drugs from an in-network pharmacy, you may find that a generic drug is automatically filled even if your doctor prescribes a brand-name drug.

Prescription Review: A Valuable Quality Review Service

Before filling your prescription, a pharmacist (either at a participating retail pharmacy or through the home delivery drug service) will enter the new prescription into the CVS/Caremark computer system to check for such things as:

- Possible drug interactions with other drugs you are taking;
- Any duplications of drugs; and
- Possible drug-induced illness (i.e., a drug you are taking that could be causing the medical condition the new prescription is prescribed to treat).

If there is a problem, the pharmacist will contact your doctor for authorization before filling the prescription. This process helps protect you from possible drug utilization problems, potentially dangerous drug interactions, and side effects.

Please note: By using your prescription drug card, you give your consent (on behalf of yourself and your covered dependents) to allow CVS/Caremark to share information with your doctors, 3M, and its contractors for the purpose of personal health care management and benefit plan administration.

Veterans Affairs (VA) Prescription Claims (90-day supply)

If you are eligible, 3M will allow up to a 90-day supply through the retail benefit of the Plan for certain VA prescription claims. VA prescriptions will be dispensed through a federal dispensing facility only, which includes the VA. This benefit was effective as of December 31, 2006.

Home Delivery Service

The Prescription Drug Feature also offers an optional home delivery service that helps you save money on maintenance drugs for on-going or long-term conditions.

Here is how the service works:

- Contact your doctor's office or ask your doctor during your next visit to write a new prescription for a 90-day supply.
- Call CVS/Caremark at (800) 700-5257 (toll free) to find out the coinsurance amount that you will need to send with your order.
- Send the new, original prescription(s) along with your CVS/Caremark Mail Service Order Form (be sure to complete the health history section) and coinsurance payment to:
CVS/Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Once CVS/Caremark has received your order, your prescription will be shipped within 10-14 days.

When the time comes to order your next refill, CVS/Caremark makes it fast and simple with easy-to-use telephone and online refill services. Simply call (800) 700-5257 (toll free) to use the automated refill system, or order online at www.caremark.com.

After you have received your second fill for the same prescription, you are encouraged to use the home delivery service or the Maintenance Choice® program. This will provide savings to you and 3M. If you decide not to use the home delivery service or Maintenance Choice® program after your second fill, you will pay an retail maintenance drug penalty of \$10 for Generics plus copay, \$35 for Preferred Brand plus copay or \$50 for Non-Preferred plus copay.

Please note that the home delivery service is available through www.caremark.com only, no “out-of-network” option exists for home delivery. Any secondary claim filled at a Mail Facility will only be reimbursed up to the 30-day retail supply limit.

Maintenance Drugs

Under the Maintenance Choice® program you are able to fill a 90-day supply of your prescription drug at your local CVS retail pharmacy. You can also purchase the same 90-day supply without a penalty at the 3M Center, Bldg. 222 on-site CarePlus Pharmacy. By using the Maintenance Choice® program you will avoid paying the retail maintenance drug penalties and the portion of prescription drug cost you pay under the Plan is the same as the home delivery service.

Your doctor's office may be contacted by a pharmacist to suggest a prescription of the same strength, for fewer doses per day, for a more convenient and efficient way to adhere to your treatment plan.

CVS Caremark will fill your first prescription of a maintenance drug for free when you switch from a brand-name drug to a generic drug. You must use the CVS Caremark home delivery program to receive your free prescription.

Covered Medications and Supplies

- FDA-approved prescription medications (legend drugs) except those listed under the sections “Not Covered”.
- Compounded medications of which at least one ingredient is legend drug.

Medications Not Covered

- Medications that are prohibited by law or are not FDA-approved.
- Nutritional supplements, regardless of the dispensing method; special diets; and supplements for weight gain or loss (except where supplements primarily serve to sustain life, as prescribed by a physician).
- Over-the-counter (non-legend) medications.
- Anti-wrinkle agents (e.g., Renova).
- Blood or blood plasma (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator). Exception: Globulin.
- Injectable infertility medications, when administered by a physician (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator).
- Minoxidil (Rogaine) for the treatment of hair loss or baldness.
- Cosmetic hair removal products (e.g., Vaniqa).
- Hair growth stimulants.
- Therapeutic devices or appliances such as insulin pumps, support garments and other non-medicinal substances, regardless of intended use.
- Drugs labeled “Caution – New Drugs – Limited by federal (United States) law to investigational use,” or experimental drugs (even if a charge is made to the individual).
- Charges for administering injections of any medications (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator).
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from physician’s original order.
- Take-home drugs after a hospital stay (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator).
- Take-home drugs from an outpatient service (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator).
- Non-sedating antihistamines or oral allergy drugs.
- Drugs billed by a hospital (may be covered by your medical plan – claims should be submitted to the medical Claims Administrator).

Note: Some of the exclusions are items that need to be administered by a physician, and charges should be submitted to the medical Claims Administrator.

Medications Requiring Prior Authorization Through Caremark

Some medications are only covered under the Plan if they are prescribed for a certain use. These drugs have the potential for serious side effects or for inappropriate use. As a result, some medications must receive prior authorization before they will be covered under the Plan.

Your pharmacist will inform you if a particular medication must receive prior authorization. Your doctor will initiate the prior authorization process for you. If coverage is denied, you will be required to pay the full cost of the medication at the time you fill your prescription. You may file an appeal using the process described in the “Prescription Claim & Appeal Procedures” section of this summary.

Even if you receive prior authorization for your prescription, some medications are still subject to special dosage and quantity limitations, regardless of what your physician prescribes.

The following is a list of the drugs that require prior authorization. This list is subject to change at any time and without notice. For the most current list, contact CVS/Caremark at (800) 700-5257 (toll-free). You also can access this information online at www.caremark.com. **You'll be required to register for the website but will then have access to information based on the 3M plan.**

- Anti-obesity
- Topical Acne (age > 25)
- ADD/Narcolepsy Drugs (age > 25)
- Botulinum Toxin A&B
- Anabolic Steroids
- Narcotic Analgesics
- All Specialty Drugs must meet Clinical Prior Authorization criteria and approval before dispensing. See www.caremark.com for list of Specialty Drugs (subject to change at any time).

Drug Limitations

Some medications are only covered under the Plan *subject to special dosage and quantity limitations*. The limits are based on clinically approved prescribing guidelines and are routinely reviewed by CVS/Caremark to ensure clinical appropriateness.

Your pharmacist will inform you if a particular medication is subject to dosage or quantity limitations. The Plan will not cover the cost of medications beyond the dosage or quantity limitations unless prior authorization is obtained. Your doctor will initiate the prior authorization process for you. If prior authorization is denied, you will be required to pay the full cost of the medication beyond the dosage or quantity limitations at the time you fill your prescription. You may file an appeal using the process described in the "Prescription Claim & Appeal Procedures" section of this summary.

The following drug categories are subject to limitations. This list is subject to change at any time and without notice.

- Erectile Dysfunction
- Sleep Hypnotics
- Migraine Medications
- Neurological Medications
- Narcotic Analgesics
- Anti Emetics
- Flu Medications

You can find out if your prescription drug is subject to limitations by calling CVS/Caremark at (800) 700-5257 (toll free). You also can access this information online at www.caremark.com. You'll be required to register for the website but will then have access to information based on the 3M plan.

3M requires you to utilize a Caremark Specialty Pharmacy. The Plan also reserves the right to limit you to one (1) doctor and one (1) pharmacy. Please contact Caremark at (800) 700 -5257 (toll free) to begin Prior Authorization process for Specialty Prescription Drugs.

Prescription Claim and Appeal Procedures

This section describes the two claims procedures used by the Prescription Drug Program:

- Standard Claims Procedure; and
- Prior Authorization Claims Procedure

The prior authorization claims procedure applies only if you are required to obtain “prior authorization.” A benefit requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization prior to receiving the benefit. Lists of the medications that require prior authorization are listed in the “Prior Authorization” and “Drug Limitations” sections of this summary.

All other claims should be submitted using the **standard claims procedure**. Even if prior authorization is required, if you receive the prescription before obtaining authorization, the standard claims procedure will apply.

CVS/Caremark is the Claims Administrator. All claims must be submitted to CVS/Caremark at:

CVS/Caremark
P.O. Box 52154
Phoenix, AZ 85072-2154

Important Notes

- If you have a concern regarding a claim, you may call CVS/Caremark at (800) 700-5257 (toll free). In many instances, working with a CVS/Caremark customer service representative will resolve most issues quickly and satisfactorily.
- Oral inquiries about coverage and benefits are not considered claims or appeals, unless specifically noted.
- Except for appeals involving urgent claims, all appeals must be submitted in writing. Appeals of urgent claims may be submitted either orally or in writing.
- All time periods described in this section are in calendar days, not business days.
- An authorized representative may file claims and appeals on your behalf. For the standard claims procedure, you must complete an authorized representative form, which is available by calling the Claims Administrator. For the prior authorization claims procedure, your healthcare provider or physician will be recognized as your authorized representative unless you direct otherwise.
- If you do not file a claim or follow the claim procedures, you are giving up important legal rights.
- An “Adverse Benefit Determination” is a denial, reduction, or termination of or a failure to provide or make payment (in whole or in part) for a Plan benefit. Such denial, reduction, or termination of or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations.
- A “Final Adverse Benefit Determination” is an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted.

Standard Claims Procedures

All claims for prescription drug benefits except those related to benefits requiring prior authorization are handled under this standard claims procedure.

Filing an Initial Claim

Deadline to File a Claim. Your claim must be received by CVS/Caremark no later than June 30th following the year in which you received the service or supply.

How to File a Claim. Generally, your pharmacist will electronically submit your initial claim directly to CVS/Caremark and payment will be made directly to them. You are responsible for paying any co-payments or co-insurance directly to the provider either at the time of your visit or when your provider sends you a bill for these amounts.

In some instances, you may need to pay your provider or pharmacist in full and then submit a claim for reimbursement to CVS/Caremark at the address indicated below. You will need to file a claim form if:

- You are purchasing a prescription “out-of-network”;
- You forget your prescription card when you pick up your medication at a participating pharmacy;
or
- You, your spouse or children have primary coverage under another medical plan.
- You can obtain a claim form from:
 - The CVS/Caremark website at www.caremark.com.
 - Or by calling CVS/Caremark at (800) 700-5257 (toll free).

Presenting a prescription to the pharmacist is not considered a claim for benefits. If you present a prescription to the pharmacist and are told that the drug is not covered or you disagree with the amount you are required to pay, you can either (1) pay for the prescription and then file a claim for reimbursement, or (2) file a claim for benefits before having the prescription filled. In either case, the procedure for filing a claim for reimbursement, described above, must be followed.

Claim Decision. CVS/Caremark has 30 days to decide your claim and to notify you if your claim is denied in whole or in part. If your claim is denied, you will receive a notice of the Adverse Benefit Determination, which will include the reason for the denial, reference to the relevant plan provision(s) and other information as required by federal law or regulations. You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of the CVS/Caremark. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide that information will not count against the time CVS/Caremark has to make its decision.

Appeals

Deadline to File an Appeal. You must file an appeal within 180 days after the date that you receive the Adverse Benefit Determination with the notice that your claim is denied.

How to File an Appeal. If you want to appeal a denied claim, contact CVS/Caremark Customer Care at (800) 700-5257 (toll free). The Customer Care representative will send you an appeal form and instruct you on how to submit your appeal.

Your written appeal must be submitted to CVS/Caremark at the address below. You should include the reason(s) you disagree with the denial of your claims and any information, documents or arguments you want considered in the 1st Level appeal. You may submit written comments, documents, records, and other information relating to your claim. Upon request you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claims process.

CVS/Caremark, Inc.
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: (866) 443-1172

Appeal Decision. The Claims Administrator has 60 days to make a decision and to notify you of that decision. If your appeal is denied, you will receive a Final Adverse Benefit Determination notice, which will include the reason for the denial, reference to the relevant plan provision(s) and other information as required by federal law or regulations.

Prior Authorization Claims Procedure

This prior authorization claims procedure applies if you are (1) seeking approval for a medication that requires “prior authorization” and (2) the prescription has not been filled. A benefit requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization from the Claims Administrator before receiving the medication. If the benefit requires prior authorization but you receive the medication before obtaining that authorization, your claim will be handled under the standard claims procedure. There are two levels of appeal under the prior authorization claim procedure. The second level of appeal is decided by an external review organization.

Prior authorization is required for the list of medications identified in the “Prior Authorization” section of this summary, as amended from time to time.

Urgent Care Claims

An “urgent” claim is a claim for a benefit that requires prior authorization and a delay in treatment could either (1) seriously jeopardize your life or health or the ability to regain maximum function or (2) in the opinion of a physician with knowledge of your medical condition, cause you severe pain.

Filing an Initial Claim

Deadline to File a Claim. Your claim must be received by CVS/Caremark no later than June 30th following the year in which you received the service or supply.

How to File a Claim. For prior authorization review, your physician should call CVS/Caremark at (888) 413-2723 (toll free). The best way to avoid inconvenience is to have your physician call the prior authorization department before you go to the pharmacy. If your physician believes that your claim is urgent, your physician should request urgent handling for the pre-service claim.

Claim Decision. CVS/Caremark has 15 days to decide your claim and to notify you if your claim is denied in whole or in part. If your claim is denied, you will receive a notice of the Adverse Benefit Determination, which will include the reason for the denial, reference to the relevant plan provision(s) and other information as required by federal law or regulations. You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of the CVS/Caremark. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide that information will not count against the time CVS/Caremark has to make its decision.

In the case of an urgent care claim, CVS/Caremark will decide the claim as soon as possible, taking into account the medical urgency, but no later than 72 hours after receipt of the claim. If an urgent care claim is incomplete, CVS/Caremark will notify the claimant as soon as possible, but no later than 24 hours

following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. CVS/Caremark will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

1st Level Appeal and Decision

Deadline to File a 1st Level Appeal. You must file an appeal within 180 days after the date that you received notice that your claim is denied.

How to File a 1st Level Appeal. If you want to appeal a denied claim, contact CVS/Caremark Customer Care at (800) 700-5257 (toll free). The Customer Care representative will send you an appeal form and instruct you on how to submit your appeal. Your written appeal must be submitted to CVS/Caremark. Appeals may be forwarded directly to the CVS/Caremark's Appeal Department by following the directions in the denial letter. You should include the reason(s) you disagree with the denial of your claims and any information, documents or arguments you want considered in the 1st appeal. You may submit written comments, documents, records, and other information relating to your claim. Upon request you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claims process. You are also entitled to receive upon request (i) the names of any medical experts who's advice was obtained in connection with the initial benefit decision (even if such advice was not relied upon in the initial benefit decision), (ii) any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision, and (iii) if the initial benefit determination is based on medical necessity, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

1st Level Appeal Decision. Once all your information has been received CVS/Caremark has 15 days (or, in the case of an urgent care claim, as soon as possible but no later than 72 hours) to make a decision and to notify you of that decision. If your appeal is denied, you will receive a notice of the Adverse Benefit Determination, which will include the reason for the denial, reference to the relevant plan provision(s) and other information as required by federal law or regulations.

2nd Level Appeal and Decision

Deadline to File a 2nd Level Appeal. You must file an appeal within 180 days after the date that you received notice that your claim is still denied.

How to File a 2nd Level Appeal. CVS/Caremark has contracted with an Independent Review Organization (IRO) to conduct independent specialist physician reviews of denials of authorization of benefits when the Plan participant or beneficiary is entitled to obtain such a review. Your written appeal must be submitted to CVS/Caremark. Appeals may be forwarded directly to the CVS/Caremark's Appeal Department by following the directions in the denial letter. You should include the reason(s) you disagree with the denial of your claims and any information, documents or arguments you want considered in the 2nd appeal. You may submit written comments, documents, records, and other information relating to your claim. Upon request, you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claim process.

2nd Level Appeal Decision. Once all your information has been received by CVS/Caremark, the IRO has 15 days (or in the case of an urgent care claim, as soon as possible but no later than 72 hours) to make a decision and to notify you of that decision. If the appeal is denied, you will receive a Final Adverse

Benefit Determination notice, which will include the reason for the denial, reference to the relevant plan provision(s) and other information as required by federal law or regulations.

3rd Level External Review

Preliminary Review. If your claim or appeal for prescription drug benefits is denied on this basis of medical judgment, you may request, in writing, a 3rd Level External Review within four (4) months after receiving notice of the Final Adverse Benefit Determination. You are eligible to request a 3rd Level External Review prior to receiving notice of the Final Adverse Benefit Determination only in the event that the Plan fails to adhere to the rules for filing an initial claim and processing a request for a 1st or 2nd Level Appeal and except in cases where the violation is attributable to good cause or outside the Plan's control and where there is no existing pattern or practice of non-compliance by the Plan.

The request should include the name of the member, the member's contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial notice. The request for External Review and supporting documentation may be mailed or faxed to CVS/Caremark:

CVS/Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Within 5 days of receiving a Plan member's request for External Review, CVS/Caremark will conduct a "preliminary review" to ensure the request qualifies. Within one day after completing this preliminary review, CVS/Caremark will notify the member, in writing, that: (i) the member's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO. If the request is complete, CVS/Caremark will assign the External Review to one of the IROs with which CVS/Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will have 10 days to provide the IRO with additional information the member wants the IRO to consider.

Timing of IRO's Determination. The IRO will provide the member and CVS/Caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review.

Reversal of the Plan's Prior Decision. If CVS/Caremark, acting on the Plan's behalf, receives notice from the IRO that it has reversed the prior determination of the member's Claim, CVS/Caremark will immediately provide coverage or payment for the Claim.

External Review Process (Expedited). If a claim is marked "urgent" by a member's physician, CVS/Caremark will process it as an urgent care claim. In some cases, CVS/Caremark may contact the physician to confirm that the claim meets the ERISA requirements for an urgent care claim, but will continue to process the claim as urgent while attempting to do so. To initiate an urgent External Review, members or their physician should call CVS/Caremark Customer Care at the toll-free number on back the benefit ID card. All requests for expedited review must be clearly identified as "urgent" at submission. The IRO must provide the member and CVS/Caremark, on behalf of the Plan, with notice of its

determination as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member's request for External Review.

Deadline to Commence a Lawsuit

If you file your claim within the required time, complete the entire claims procedure, and your appeal is denied, you may sue over your claim (unless you have executed a release of your claim). You must, however, commence that suit within two (2) years after you knew or reasonably should have known of the facts behind your claim or, if earlier, within six (6) months after the claims procedure is complete.

When Coverage Ends

Coverage for you will end upon any of the following:

- Your employment with 3M or a participating 3M affiliate ends for any reason;
- Your portion of the required premium, contribution or other required payment is not paid timely;
- The Plan is terminated or amended such that you are no longer eligible for coverage;
- You no longer meet the eligibility requirements;
- You elect to end coverage;
- Your death; or
- You attempt to obtain benefits fraudulently for yourself or others (such as enrolling an ineligible dependent) or otherwise violate the terms of the Plan as determined by the Plan Administrator.

Coverage for your covered dependents will end upon any of the following:

- Your coverage ends;
- Your portion of the required premium, contribution or other required payment is not paid timely;
- The Plan is terminated or amended such that your covered dependent is no longer eligible for coverage;
- Your covered dependent no longer meets the eligibility requirements;
- Your covered dependent elects to end coverage;
- Your covered dependent's death; or
- Your covered dependent attempts to obtain benefits fraudulently for himself/herself or others or otherwise violate the terms of the Plan as determined by the Plan Administrator.

In addition, as described elsewhere in the Summary, benefits may not be payable or may be reduced, terminated or suspended under certain circumstances even if you are otherwise covered under the Plan.

In most events, including loss of eligibility due to divorce, legal separation, death or loss of dependent status, coverage ends on the day of the event resulting in loss of coverage. However, in the event your employment ends for any reason or you go on a leave of absence resulting in loss of coverage, coverage ends on the last day of the pay period in which your employment ended or you began your leave.

If coverage ends for you or your dependents a temporary extension may be available in certain circumstances. See the "Continuing Your Coverage" section for more information.

Certification of Coverage

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

The certification of coverage form will be issued to you if you request it before losing coverage or when you terminate coverage with the group and, if applicable, at the expiration of any continuation period. The 3M FIRST Line Center will also issue the certification of coverage form if you request a copy at any time within the 24 months after your coverage terminates.

Extension of Benefits

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

Continuing Your Coverage

General Notice of COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of coverage under a 3M group health plan (“Plan”) after you or your family loses coverage in certain circumstances. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have questions about your COBRA continuation rights, please contact the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. - 6 p.m. CST, Monday through Friday.

COBRA continuation coverage is available under the Plan. COBRA continuation coverage can become available to you and your family members when you and your family members would otherwise lose health coverage under the Plan due to certain events. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA Eligibility

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event (and any required notice of that event is properly provided), COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Generally, in an employee health plan, only your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. As discussed below, there is one circumstance in which you could be a qualified beneficiary as well. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

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

- Your spouse dies
- Your spouse’s hours of employment are reduced
- Your spouse’s employment ends for any reason other than his or her gross misconduct
- You become divorced or legally separated from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, the ex-spouse may still be entitled to COBRA continuation coverage even though he or she lost coverage before the divorce or legal separation. It is therefore important for the ex-spouse to notify 3M of the divorce or legal separation even if coverage had been eliminated earlier. The ex-spouse will need to follow the procedures outlined below for providing such notice.)

Your dependent children (including children participating under a Qualified Medical Child Support Order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- Parent- employee dies
- Parent-employee's hours of employment are reduced
- Parent-employee's employment ends for any reason other than his or her gross misconduct
- Parents become divorced or legally separated
- Child stops being eligible for coverage under the Plan as a dependent child

Notification of COBRA Continuation Coverage Election

You Must Give Notice of Some Qualifying Events

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify 3M of any of these three qualifying events.

For other qualifying events you must notify 3M of certain qualifying events. These events include the divorce or legal separation of the employee and spouse, and a dependent child's losing eligibility for coverage. A COBRA election will be available only if you, your spouse or your dependent notify 3M of the qualifying event within 60 days after the later of (1) the date of the qualifying event and (2) the date on which your spouse or your dependent loses (or would lose) coverage under the terms of the plan as a result of the qualifying event. The next paragraphs explain the procedure to provide this notice.

Employees should notify 3M of the qualifying event by calling 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday. You must notify 3M FIRST Line Center of the qualifying event by the 60 day deadline described above. The 60-day period is extended to the next business day if the last day of the 60-day election period falls on a Saturday, Sunday, or legal holiday. On the call you will be asked to furnish your name, the names of all qualifying beneficiaries affected by the event, the qualifying event that has occurred, the date of the qualifying event, and your address and the addresses of any qualifying beneficiaries who do not live with you. You may be required to submit evidence of the qualifying event.

If you are not a 3M employee, you should notify 3M of the qualifying event in writing by completing a Qualified Beneficiary Notice Form. To request a Qualified Beneficiary Notice Form, call the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

The Qualified Beneficiary Notice Form can be completed and mailed to: 3M, P.O. Box 1197, Carol Stream, IL 60132-1197. You can also fax a completed Qualified Beneficiary Notice Form to (847) 883-8538 to the attention of the 3M. If mailed, the Qualified Beneficiary Notice Form must be postmarked no later than the deadlines described above. If faxed, the Qualified Beneficiary Notice Form must be sent by the deadlines described above. To complete the Qualified Beneficiary Notice Form, you will have to furnish your name, the names of all qualifying beneficiaries affected by the event, the qualifying event that has occurred, the date of the qualifying event, and your address and the addresses of any qualifying beneficiaries who do not live with you. If you are notifying 3M of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. You may be required to submit other or additional evidence of the qualifying event.

You must provide notice in a timely manner. If you, your spouse or your dependent fails to provide notice in the manner outlined above during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Election of COBRA Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You (and any qualified beneficiary) will have 60 days after the date of the COBRA election notice (or, if later, 60 days after the date coverage is lost) to decide whether to elect COBRA under the Plan. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under the Plan would otherwise end.

Procedures to Elect COBRA Continuation Coverage

After proper and timely notice of a qualifying event, you will be sent a COBRA Enrollment Notice. To elect COBRA continuation coverage, you, your spouse or your dependents must complete the enrollment election by calling 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada within 60 days from the date of the COBRA Enrollment Notice (or, if later, the date coverage is lost) according to the directions on the form. If you (on behalf of your spouse or dependents) or your spouse and dependent children do not elect continuation coverage within this period, your spouse and/or dependents will not receive continuation coverage. If mailed, your enrollment election must be post-marked no later than the last day of the 60-day election period. Otherwise it must be actually received by the entity indicated on the Election Form no later than that day.

Special Considerations in Deciding Whether to Elect COBRA

If you experience a qualifying event, in considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue group health coverage under the Plan will affect their future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect and remain covered under COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by their employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you remain covered under COBRA continuation coverage for the maximum time available to you.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility, COBRA continuation coverage lasts for up to 36 months. In the event of your death, your spouse and dependents may be eligible to continue coverage under the Plan after COBRA continuation coverage ends. This coverage is separate from COBRA continuation coverage and special rules and restrictions apply. For more information, you should call the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to 18 months.

There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify 3M in a timely fashion, you and all qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day after termination of employment or reduction in hours and must last at least until the end of the 18-month period of COBRA continuation coverage.

To obtain the 11-month extension, you must notify 3M in writing of the Social Security Administration's determination within 60 days of the latest of: the date of the disability determination, the date of the qualifying event, and the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must also provide the notice before the end of the 18-month period of COBRA continuation coverage. **If no notice is given within the required period, then there will be no disability extension of COBRA continuation coverage.**

To obtain the 11-month disability extension, you must timely notify 3M in writing that you are requesting the extension by completing a Qualified Beneficiary Notice Form. To request a Qualified Beneficiary Notice Form, call the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

The Qualified Beneficiary Notice Form can be completed and mailed to: 3M, P.O. Box 1197, Carol Stream, IL 60132-1197. You can also fax a completed Qualified Beneficiary Notice Form to (847) 883-8538 to the attention of the 3M COBRA and Direct Bill Processing Center. If mailed, the Qualified Beneficiary Notice Form must be postmarked no later than the deadlines described above. If faxed, the Qualified Beneficiary Notice Form must be sent by the deadlines described above. To complete the Qualified Beneficiary Notice Form, you will have to furnish your name, the names of all qualifying beneficiaries affected by the event, and the date of the Social Security disability determination. Your notice must also include a copy of the Social Security Awards Determination letter. You may be required to submit additional evidence of the Social Security disability determination.

You also must notify 3M immediately if the Social Security Administration determines that you are no longer disabled by calling the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

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

If your qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children who are qualified beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months (including the initial 18-month period), if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if a dependent child stops being eligible under the Plan as a dependent child. In all of these cases, the extension is available only if the event would have caused your spouse or dependent child to lose coverage under the terms of the Plan had the first qualifying event not occurred. **If you or a qualified beneficiary experience a second qualifying event, you must notify 3M within 60 days of its occurrence. If you do not timely notify 3M in accordance with the procedures below, your qualified beneficiaries will not receive an extension of COBRA continuation coverage.**

If you experience a second qualifying event, you or your qualified beneficiary should notify 3M of the second qualifying event in writing by completing a Qualified Beneficiary Notice Form. To request a Qualified Beneficiary Notice Form, call the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

The Qualified Beneficiary Notice Form can be completed and mailed to: 3M, P.O. Box 1197, Carol Stream, IL 60132-1197. You can also fax a completed Qualified Beneficiary Notice Form to (847) 883-8538 to the attention of the 3M COBRA and Direct Bill Processing Center. If mailed, the Qualified Beneficiary Notice Form must be postmarked no later than the 60-day deadline described above. If faxed, the Qualified Beneficiary Notice Form must be sent by the 60-day deadline described above. To complete the Qualified Beneficiary Notice Form, you will have to furnish your name, the names of all qualifying beneficiaries affected by the event, the qualifying event that has occurred, the date of the qualifying event, and your address and the addresses of any qualifying beneficiaries who do not live with you. If you are notifying 3M of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. You may be required to submit other or additional evidence of the second qualifying event.

Medicare extension for spouse and dependent children

If a covered employee (i) experiences a qualifying event that is either termination of employment or a reduction of hours, and (ii) that qualifying event occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA continuation coverage will end 36 months from the date the employee became entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). If you believe your spouse or dependent children qualify for this Medicare extension, you or your qualified beneficiary should call the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. – 6 p.m. CST, Monday through Friday.

COBRA-Like (Continuation) Coverage

Although current federal law does not provide COBRA rights to eligible domestic partners and their child(ren), 3M offers a similar opportunity to continue medical and dental coverage for a limited time when it ends due to certain events.

Your covered domestic partner and/or covered child(ren) of your domestic partner may elect continuation of coverage for up to 18 months if their 3M medical and/or dental coverage ends due to your hours of employment being reduced or your employment ending for any reason other than gross misconduct.

Your covered domestic partner and/or covered child(ren) of your domestic partner may elect continuation of coverage for up to 36 months if their 3M medical and/or dental coverage ends due to your death, or if your domestic partnership ends. In addition, a covered child(ren) of your domestic partner may elect continuation coverage for up to 36 months if the child stops being eligible for coverage as a dependent child.

The cost of this continuation coverage must be paid on a monthly basis, with contributions based on the full cost of coverage, plus 2% for administrative costs.

Cost of Continuation Coverage

Each qualified beneficiary will be required to pay the entire cost of COBRA continuation coverage plus a 2% administrative fee. If you are eligible for an 11-month extension of continuation coverage due to disability, you will be required to pay up to 150 percent of the otherwise applicable cost during such 11-month extension period. The amount of COBRA premiums can be increased from time to time during your period of COBRA coverage to the extent permitted by federal law.

Payment for COBRA Continuation Coverage

You will not be considered to have made any COBRA payment if their check is returned due to insufficient funds or otherwise.

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, no payment has to be sent at the time of the enrollment election. However, the first payment for COBRA continuation coverage must be made not later than 45 days after the date of your election. (This is the date the enrollment election is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of the first payment is correct. To confirm the correct amount of your first payment, you can call 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. - 6 p.m. CST, Monday through Friday.

At the time of your election you will be told where to send your first payment.

Periodic payments for COBRA continuation coverage

After you make your first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If mailed, COBRA payment must be postmarked on or before the first of the month to be timely. If you make a periodic payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan may not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment.

Grace periods for periodic payments

Although periodic payments are due on the first of each month, you will be given a grace period of 30 days after the first day of the month to make each periodic payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If mailed, COBRA payment must be postmarked on or before the end of the grace period.

If you fail to make a periodic payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated and you will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage will automatically terminate before the end of the maximum period if (i) any required premium is not paid in full on time, (ii) after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan (but only after any preexisting

condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted), (iii) after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both), or (iv) the employer ceases to provide any group health plan for its employees. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If you become covered under another group health plan or you enroll in Medicare, you must notify the 3M FIRST Line Center immediately. You, your spouse or your dependent should contact the 3M FIRST Line Center at (888) 611-5500 (toll free) if in the U.S. and Canada, or (847) 883-0483 if outside the U.S. and Canada. The 3M FIRST Line Center hours are 8 a.m. - 6 p.m. CST, Monday through Friday.

Special “Trade Act” Rules Concerning Tax Credit for COBRA Continuation Coverage

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (“eligible individuals”). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. In addition, an eligible individual who did not elect COBRA continuation coverage when first available may be eligible for a special second election period. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center at (866) 628-4282 (toll free). TTD/TTY callers may call at (866) 626-4282 (toll free).

Keep Your Plan Informed of Address Changes

In order to protect you and your family’s rights, you should keep 3M FIRST Line Center informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you or a family member send to 3M FIRST Line Center.

Employment Changes

FMLA Leaves of Absence

If you go on an approved unpaid Family/Medical Leave, you will be able to continue coverage pursuant to the Family and Medical Leave Act (FMLA) and 3M policy, and a letter outlining your benefit options will be mailed to your home. If annual enrollment occurs while you are on Family/Medical Leave, you will receive an annual enrollment opportunity.

For detailed information on your rights and obligations while on FMLA Leave, contact the 3M Disability Claim Administrator at (800) 543-5562 (toll free) or (651) 737-8705. A copy of 3M's FMLA policy is available upon request or on 3M Source: Life & Career > Quick Links-HR Policies & Plan Documents > Human Resource Policies > Benefits > Family Medical Leave Policy.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Disability

If you become disabled and are approved for benefits under the 3M Long-Term Disability (LTD) Plan, your medical coverage will continue as long as you remain approved for Long-term Disability. Your continued coverage is subject to all the terms and conditions of the Plan, including the rules on when coverage ends. See the section titled "When Coverage Ends" for more information.

In the event you have an LTD overpayment, when return from your LTD, your medical coverage will be reinstated to the first of the month that the LTD overpayment is repaid. If you do not have an LTD overpayment, your dental coverage will begin your first day back from LTD.

Medicare Eligibility Due to Disability

Once you (or an eligible dependent) become eligible for Medicare due to disability, you may be automatically enrolled in Medicare Part A. However, you need to enroll in Medicare Part B to receive maximum coverage under Medicare. Enrollment in Medicare may be deferred while you are actively employed. Medicare coverage is secondary to the Medical Plan coverage for an employee who is actively at work.

However, once you are eligible for Medicare and you are not actively working, you should enroll in Medicare Part A and Medicare Part B. Benefits paid under the 3M Plan will be coordinated with Medicare and will be based on what Medicare would pay on an expense. Medicare will become your primary coverage. If you or your dependent does not elect Medicare Parts A and B coverage when eligible, the Plan coverage will not reimburse that portion of your expenses that Medicare would have paid had you had Part A and B coverage.

Coordination of Benefits/Non-duplication of Benefits

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under this Plan are not reduced if the Order of Benefits Rules require this Plan to pay first. If the 3M Plan is the secondary plan, the combined coordinated payment from the other plan and the 3M Plan will not be more than the benefit that would be paid by the 3M Plan if it were your only coverage. The same rule applies when both spouses work for 3M. This is referred to as Non-duplication of benefits.

Definitions

These definitions apply only to this section.

1. “Plan” is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
 - a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage (group coverage is always primary and pays first);
 - b. coverage under a government plan or one required or provided by law; or
 - c. individual coverage;
 - d. the medical payment (“medpay”) or personal injury protection benefit available to you under an automobile insurance policy.

“Plan” does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). “Plan” does not include any benefits that, by law, are excess to any private or other nongovernmental program.

If any of the above coverage include group and group-type hospital indemnity coverage, “This Plan” only includes that amount of indemnity benefits which exceeds \$100 a day.

2. “This Plan” means the part of the Plan document that provides health care benefits.
3. “Primary Plan/Secondary Plan” is determined by the Order of Benefits Rules.

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

When you are covered under more than two (2) plans, This Plan may be a primary plan to some plans, and may be a secondary plan to other plans.

Notes:

- a. If you are covered under this Plan and Medicare: this Plan will comply with Medicare Secondary Payor (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a primary Plan and which is a Secondary Plan. Medicare will be primary

and this Plan will be secondary only to the extent permitted by MSP rules. When Medicare is the Primary Plan, this Plan will coordinate benefits up to Medicare's allowed amount.

- b. If you are covered under This Plan and TRICARE: this Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefit's Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan, TRICARE will be primary and this Plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the Primary Plan, this plan will coordinate benefits up to TRICARE'S allowed amount.
4. "Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or This Plan. "Allowable Expenses" does not include outpatient prescription drugs, except those eligible under Medicare (see number 3 above).

The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under this Plan.

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

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

Order of Benefits Rules

1. General: When a claim is filed under this Plan and another plan, this Plan is a secondary plan and determines benefits after the other plan, unless:
 - a. the other plan has rules coordinating its benefits with this Plan's benefits; and
 - b. the other plan's rules and this Plan's rules, in part 2. below, require this Plan to determine benefits before the other plan.
2. Rules: this Plan determines benefits using the first of the following rules that applies:
 - a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
 - b. Nondependent/dependent: the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
 - c. Dependent child of parents not separated or divorced: When This Plan and another plan cover the same child as a dependent of different persons, called "parents":

- 1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
- 2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

- d. Dependent child of parents divorced or separated or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Plan determines benefits in this order:
 - 1) first, the plan of the parent with physical custody of the child;
 - 2) then, the plan that covers the spouse of the parent with physical custody of the child;
 - 3) finally, the plan that covers the parent not having physical custody of the child; or
 - 4) in the case of joint physical custody, b. above applies.

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

- e. Active/inactive employee: The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
- f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

Coordination of Benefits: Two Examples

Here's how coordination of benefits works. Assume you have the \$275 individual/\$550 family deductible with coverage for you and your spouse, and you use a In-Network Provider for services (the Plan pays 90% of covered expenses). You and your spouse are also covered under the XYZ Company plan that pays 80%. All deductibles are met.

Example 1 – 3M pays primary, your spouse's plan pays secondary

You are ill and receive \$100 of medical care.

- 3M pays benefits first; 90% of \$100 = \$90.
- You submit claim to the XYZ Company's plan.
- XYZ Company pays according to its coordination of benefits rules.

Example 2 – your spouse’s plan pays primary, 3M pays secondary

Your spouse is ill and receives \$100 of medical care.

- XYZ Company pays benefits first; 80% of \$100 = \$80. Spouse submits claim to 3M Medical Plan.
- 3M would pay up to 90%. 80% has already been paid by XYZ.
- 3M pays the difference between 90% and 80%.
- 3M pays 10%, or \$10.

Effect on Benefits of This Plan

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, this Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Reimbursement and Subrogation

The Plan maintains both a right of reimbursement and a separate right of subrogation. If you or your dependents receive benefits under the Plan arising out of an illness or injury for which a responsible party is or may be liable, the Plan shall be subrogated to your claims and/or your dependents' claims against that responsible party, and the Plan is entitled to be reimbursed, for 100 percent of benefits paid by the Plan. You must reimburse the Plan immediately from any Amounts before you or your dependents (including minors) are entitled to keep such Amounts and regardless of whether the Amounts represent a full or partial recovery by you. The Plan's subrogation and reimbursement rights apply to these Amounts as a first priority claim, and extend to 100% of benefits paid by the Plan, regardless of whether you have been fully compensated or "made whole" (that is, regardless of whether your recovery is full or partial) and whether these Amounts are characterized as reimbursement for lost wages, medical or dental expenses, or for some other loss. The Plan's share of any recovery of the Amounts will not be reduced because you did not receive the full amount of damages claimed. Amounts must be used to reimburse the Plan before any other claims that may exist are paid, including claims for general damages.

The Plan shall have a lien on all Amounts recovered by you, your dependents, your attorneys or other representatives. This lien shall remain in effect until the Plan is repaid in full. In addition, until the Plan has been reimbursed for the amount of all benefits paid under the Plan, all Amounts that you, your dependents, your attorneys or other representatives receive shall be held in constructive trust for the Plan, whether such Amounts remain with you or with some other person or entity.

The Plan may take any action as it deems necessary and appropriate to protect, secure and enforce its subrogation and reimbursement rights, including bringing suit in your and/or your dependent's name or intervening in any action to secure its subrogation and reimbursement rights. The Plan may require you to assign to the Plan the right to bring an action against a third party. The Plan may file an equitable lien or seek a constructive trust or other relief against you, another person or entity or any Amounts to secure its subrogation and reimbursement rights. The Plan may require you to sign a reimbursement agreement. The Plan has a right to be reimbursed in full regardless of whether you actually sign the agreement. If you fail to reimburse the Plan, and the Plan determines it necessary to enforce its reimbursement rights in court, you shall be liable and agree to pay for court costs and attorneys' fees incurred by the Plan.

The Plan Administrator may authorize the Claims Administrator or another third-party to protect the Plan's subrogation and reimbursement rights, and to negotiate and compromise the Plan's subrogation and reimbursement claims.

As used in this section, "Amounts" means any recoveries, settlements, judgments, or other amounts that you, your dependents, attorneys, heirs, guardians, executors, trustees or other representatives receive, are awarded, or become entitled to from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for: (1) the accident, injury, sickness or condition that resulted in benefits being paid under the Plan and/or (2) the loss of wages, medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Plan.

Duty to Cooperate

You, your dependents, your attorneys and other representatives must cooperate with the Plan and 3M in assisting the Plan to protect and enforce its subrogation and reimbursement rights. This means that you must take no action—including, but not limited to, settlement of any claim—that prejudices or may prejudice the Plan's subrogation and reimbursement rights. As soon as you become aware of any claims

or Amounts for which the Plan is or may be entitled to assert subrogation and/or reimbursement rights, you must inform the Plan, by providing written notification to the Claims Administrator of:

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

You and your dependents must provide this information as soon as possible, and, in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives: (1) agree to any settlement or compromise of such claims; or (2) bring a legal action against any other party.

In addition, as part of your duty to cooperate, you and your dependents must complete and sign all forms and papers as required by the Plan and provide any other information required by the Plan.

Attorneys' Fees and Other Expenses You Incur

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

What May Happen to Your Future Benefits

If you receive benefits under the Plan after you receive a recovery pursuant to a release or waiver of any kind that discharges another individual or entity that was or may have been liable for the benefits received, the Plan shall pay benefits only for amounts that exceed the amount recovered (or the amount that should or would have been recovered but for the release or waiver).

If the Plan determines that you, your dependents, your attorneys or other representatives have failed to cooperate or reimburse the Plan, the Plan may reduce future benefits or payments, which includes all benefits payable under the Plan for you and your dependents and not just benefits relating to the injury or illness for which you recovered Amounts, and may terminate coverage under the Plan for you and your dependents. This right will not be limited to benefits for the person related to the injury or illness, but will apply to all benefits otherwise payable under the Plan for you and your dependents.

Employee Retirement Income Security Act (ERISA) Statement of Rights

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

- **Receive Information About Your Plan and Benefits**
 - Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
 - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
 - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- **Continue Group Health Plan Coverage**
 - Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.
 - Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

Important Plan Information

Plan Administrator

The Plan Administrator shall have the discretionary power and authority to (i) control and manage the operation of the Plan, (ii) prescribe applicable Plan procedures, (iii) make all decisions and determinations with respect to the Plan, and (iv) interpret and apply the terms of the Plan. This discretionary power and authority includes, without limitation, determining all factual and legal questions, interpreting any ambiguous or unclear terms in the Plan and the underlying documents, deciding eligibility for coverage and eligibility for benefits and establishing rules to carry out administration of the Plan. All determinations, interpretations, rules and decisions of the Plan Administrator will be made, in its sole discretion, and will be final, conclusive and binding as to all parties. In any legal action, all explicit and all implicit determinations by the Plan Administrator shall be afforded the maximum deference permitted by law. The Plan Administrator may delegate all or a portion of its powers, authority, responsibilities, discretion and rights under the Plan to an individual, entity or committee. Any delegation may, if specifically stated, allow further delegation by the individual, entity or committee to whom the delegation has been made. The Plan Administrator reserves the right to correct any errors, defects, inconsistencies and omissions that may occur in the administration of the Plan as the Plan Administrator, in its discretion, determines appropriate, including reducing or eliminating benefits under the Plan, and such correction shall be final and binding all persons. Subject to any delegation of authority, the Plan Administrator shall be the named fiduciary for the purposes of ERISA.

Claims Administrator

The Plan Administrator has contracted with the Claims Administrator to assist in the handling of benefit determinations under the Plan and to provide assistance in the administration of the Plan. The Claims Administrator will have the authority to make benefit determination under the Plan and direct payments with respect to the Plan, and will have such other responsibility and authority as delegated by the Plan Administrator.

Benefit Determinations

The Plan Administrator delegates its full and final discretionary power and authority with respect to benefit determinations to the Claims Administrator. This power and authority includes, without limitation, determining all factual and legal questions, interpreting any ambiguous or unclear terms in the Plan and the underlying documents, determining the amount of benefits, if any, to which an individual is entitled to under the Plan, deciding the manner and terms of payment, prescribing forms to be used and procedures to be followed in applying for benefits and appealing any adverse benefit decision under the Plan, and deciding all claims for benefits, adverse benefit determinations and appeals. The Claims Administrator has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall only be paid if the Claims Administrator decides, in its discretion, that an individual is entitled to them. With respect to benefit determinations, all determinations, interpretations, rules and decisions of the Claims Administrator shall be final, conclusive and binding as to all parties. This delegation of authority shall not, however, apply to determinations pertaining to eligibility to participate in the Plan, which shall remain with the Plan Administrator. With respect to its delegated authority, the Claims Administrator is a named fiduciary under the Plan.

Amendment or Termination

3M reserves the right to amend and terminate the Plan in whole or in part, at any time and in any respect and for any reason and either prospectively or retroactively or both. 3M's right to amend or terminate the Plan includes, without limitation, changes in the eligibility requirements, cost-sharing and funding arrangements, benefits provided and termination of all or a portion of the coverage provided under the

Plan. No oral statements or representations can amend the Plan. 3M makes no promise to continue the Plan or the benefits offered under the Plan in the future, and individuals have no vested right to the Plan or the benefits offered under the Plan.

Benefit Adjustments

The Plan Administrator, in its discretion, may restrict enrollment and/or adjust an individual's benefits to enable the Plan to comply with requirements imposed by the law or required to comply with nondiscrimination provisions of an applicable law, including without limitation ERISA or the Code. In addition, all benefits payable under the Plan are subject to set-off for any debts owed by an individual to the Plan or 3M to the extent permitted by law as well as for any reimbursement rights the Plan has against the individual or a third party.

Recovery of Overpayment

If a benefit payment to you or on your behalf exceeds for any reason the benefit amount you are entitled to receive in accordance with the terms of the Plan, the Plan Administrator has the right to require the return of the overpayment on request, and upon request you must immediately refund the overpayment as well as help the Plan Administrator obtain the refund of the overpayment from another person or entity. This includes any overpayment resulting from retroactive awards received from any source, fraud or any error made in processing your claim. The Plan Administrator also has the right, at its option, to recover the overpayment by reducing or offsetting against any future benefit payments. Such rights do not affect any other right of recovery the Plan Administrator may have with respect to such overpayment and the Plan Administrator reserves the right to obtain the overpayment by any other method permitted by the law. The Plan Administrator will determine in its sole discretion the method by which the repayment of the overpayment shall be made.

Assignment Prohibited

Except as permitted by this Summary or the Plan Administrator, no individual shall have any transmissible interest in any benefit under the Plan or any power to anticipate, alienate, dispose of, pledge or encumber the same, not nor shall 3M recognize an assignment thereof, either in whole or in part, nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process.

The employer is not required to reimburse anyone other than you for covered expenses when you use Nonparticipating Providers. It is your responsibility to arrange for the payment of those expenses and then get reimbursed from the Plan. Except as may be required by law, your benefits under the Plan are not subject to the claims of your creditors.

Misconduct

If the Plan Administrator determines that an individual has engaged in fraud or made misrepresentations with respect to the Plan, engaged in illegal behavior in connection with the Plan, failed to provide requested information or sign any required documentation, failed to cooperate with 3M or the Plan, or otherwise engaged in behavior determined by the Plan Administrator to be detrimental or adverse to the Plan, the Plan Administrator reserves the right to terminate coverage under the Plan for the individual and that individual's dependents. In the case of fraud or an intentional misrepresentation of a material fact, the Plan Administrator reserves the right to rescind coverage and deny claim payments retroactively as well as recover any and all benefit payments already made. 3M also reserves the right to take disciplinary action and all other civil and criminal recourse for such actions.

Right to Information

The Plan Administrator and Claim Administrator shall have the right to require any person claiming eligibility to participate in, or benefits under, the Plan to (a) furnish any information or documentation it determines necessary, (b) certify or sign an affidavit attesting to certain facts, and (c) undertake a medical examination or an autopsy in the case of death. These rights are in addition to, not in lieu of, any rights of the Plan Administrator and Claims Administrator set forth in the Summary.

Individual Contributions

3M will determine the amount and manner an individual will be charged for coverage under the Plan. Individuals shall not be entitled to any refunds, rebates, discounts or other arrangements based on the actual cost of providing benefits under the Plan. 3M has complete discretion to apply any payments received from an insurer, including premium rebates based on experience, dividends, settlements and proceeds from demutualization to reduce its contributions to the Plan.

Funding

3M has established a separate trust fund, called a Voluntary Employees' Beneficiary Association (VEBA), to fund the Plan. To the extent that any benefits are not funded through a VEBA or other trust, 3M will pay such benefits directly from its general assets. The VEBA is funded by contributions from the employer and/or employees. Your contribution toward the cost of coverage under the Plan will be determined by the Employer each year.

Use of Forfeitures

Forfeitures under the Plan can be used, at the sole discretion of the Company, to reduce the cost of administering the Plan or to pay for other Plan expenses and for any other purpose permitted under the law.

Plan Expenses

3M may pay the expenses of administering the Plan; however, if 3M does not pay for an expense, then the expense shall be paid out of plan assets.

Governing Law

The Plan shall be construed in accordance with the applicable provisions of ERISA and the Code and, to the extent not preempted by federal law, in accordance with the laws of the State of Minnesota. Any litigation commenced or arising in connection with the Plan shall be commenced and venued exclusively in the United States District Court for the District of Minnesota.

Unclaimed Property

Any benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited.

Satisfaction of Claims

Any payment to or for the benefit of any individual, legal representative or person chosen in accordance with the provisions of the Plan shall, to the extent of the payment, be in full satisfaction of all claims against the Plan and 3M, either of which may require the payee to execute a receipted release as a condition precedent to the payment.

Privacy of Protected Health Information

Effective April 14, 2003, the Plan became subject to federal privacy requirements established by the Health Insurance Portability & Accountability Act of 1996 (“HIPAA Privacy Rules”), which require the Plan to protect the privacy of information about your health and that of your dependents. The Plan is permitted under the HIPAA Privacy Rules to share your and your dependents’ protected health information with 3M Company and third parties (including the Claims Administrator) for certain purposes, such as operation of the Plan and payment of claims. For more information, you should review the Plan’s Notice of Privacy Practices. You have a right to request a copy of this notice.

Plan Name:	HealthPartners PPO 3M Medical Plan, a component program of the 3M Employees’ Welfare Benefits Association (Trust II) Plan
Type of Plan:	The Plan is a welfare benefit plan providing health care benefits
Plan Year:	The plan year is the calendar year beginning each January 1 and ending each December 31.
Plan Number:	523
Employer/Plan Sponsor:	3M Company 3M Center 224-2W-15 St. Paul, MN 55144 (877) 496-3636 (toll free) (651) 575-5000 (Twin Cities)
Participating Employers:	You may obtain a complete listing of participating companies and subsidiaries by contacting the Plan Administrator.
Plan Sponsor’s Employer Identification Number:	41-0417775
Plan Administrator:	3M’s Vice President, Global Compensation and Benefits or his or her successor, is the Plan Administrator. Global Compensation and Benefits 3M Company 3M Center St. Paul, MN 55144-1000 (877) 496-3636 (toll free) (651) 575-5000 (Twin Cities)
Enrollment Administrator:	3M FIRST Line Center 100 Half Day Road Lincolnshire, IL 60069-3242 (888) 611-5500 (toll free)

Claims Administrator for Medical (other than Prescription Drug and Routine Vision Features):

HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289
(952) 883-5144 (Twin Cities)
(877) 435-7616 (toll free)

Claims Administrator for Prescription Drug Feature:

CVS/Caremark
P.O. Box 52154
Phoenix, AZ 85072-2154
(800) 700-5257 (toll free)

Claims Administrator for the Routine Vision Feature:

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195 (toll free)

Trustee:

Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149
(617) 722-7000

Agent for Services of Legal Process:

3M Company
3M Center
Secretary
224-2W-15
St. Paul, MN 55144

Service of legal process may also be made on the Plan Administrator and the Trustee.

Glossary of Common Terms

Please refer to the **Benefit Chart** for specific benefit and payment information.

Admission	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
Advanced practice nurses	Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
Allowed amount	The amount upon which payment is based for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the Benefit Chart.

The Allowed Amount for Participating Providers

For Participating Providers, the allowed amount is the negotiated amount of payment that the Participating Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating Providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per service allowed amount for such covered services.

Through settlements or other special arrangements with Participating Providers the Claims Administrator may prospectively or subsequently pay a different amount to a Participating Provider. Such payments will not affect or cause any change in the amount you paid at the time your claim was processed.

Qualifications Applicable to All Nonparticipating Providers

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this allowed amount is a usual, customary, or reasonable charge from a provider. The allowed amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the allowed amount is subject to all of the Claims Administrator's business rules as defined in the Claims Administrator Provider Policy and Procedure Manual. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The Allowed Amount for Nonparticipating Providers in Minnesota

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; or (4) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.

The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota

For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the allowed amount will be an amount based upon one of the following payment options, to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) a percentage of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by the Host plan; or (5) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option.

Special Circumstances

When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the allowed amount and the provider's billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. The extent of reimbursement in these circumstances may also be subject to federal law.

If you have questions about the benefits available for services to be provided by a Nonparticipating Provider, you will need to speak with your provider and you may call the Claims Administrator Customer Service at the telephone number on the back of your member ID card for more information.

Artificial Insemination (AI)

The introduction of semen from a donor (which may have been preserved as a specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Reproductive Technologies (ART)	Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine insemination (IUI), or artificial insemination (AI)), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.
Attending health care professional	A health care professional with primary responsibility for the care provided to a sick or injured person.
Average semiprivate room rate	The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.
Calendar year	The period starting on January 1 st of each year and ending at midnight December 31 st of that year.
CareCheck[®] Service Care/case management plan	<p>This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care.</p> <p>A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.</p>
CareLineSM Service	This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist covered persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.
Charge	<p>For covered services delivered by participating network providers, is the provider's discounted charge for a given medical/surgical service, procedure or item.</p> <p>For covered services delivered by out-of-network providers, this is the provider's charge for a given medical/surgical service, procedure or item, according to the usual and customary charge allowed amount.</p> <p>The usual and customary charge is the maximum amount allowed which the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.</p> <p>A charge is incurred for covered ambulatory medical and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient services on the date of admission to a hospital. To be covered, a charge must be incurred on or after the covered person's effective date and on or before the termination date.</p>

Claim

A written submission from your provider (or you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is not covered, the claim will be denied, meaning no payment is allowed.

Providers are required to use certain codes to explain the care they give you. The provider's medical records must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to contact your provider.

Claims Administrator

Health Partners Administrators, Inc.

Copayment/Coinsurance

The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a covered person must pay, each time a covered person receives certain medical services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SPD.

For services provided by a network provider:

The amount which is listed as a percentage of charges or coinsurance is based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by an out-of-network provider:

Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Comprehensive pain management program

A multidisciplinary program including, at a minimum, the following components:

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

Continuous qualifying creditable coverage	The maintenance of continuous and uninterrupted creditable coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous qualifying creditable coverage if the individual applies for coverage within 63 days of the termination of his or her qualifying creditable coverage.
Cosmetic services	Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.
Covered services	A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.
Custodial care	Services to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.
Cycle	One partial or complete fertilization attempt extending through the implantation phase only.
Day treatment	Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.
Deductible	The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a covered person or a covered family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For network providers, the amount of charges that apply to the deductible are based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For out-of-network providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.
Durable medical equipment	Medical equipment prescribed by a physician that meets each of the following requirements: <ol style="list-style-type: none"> 1. Able to withstand repeated use; 2. Used primarily for a medical purpose; 3. Generally not useful in the absence of illness or injury; 4. Determined to be reasonable and necessary; and 5. Represents the most cost-effective alternative.

Emergency hold	A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.
Enrollment date	The first day of coverage, or if there has been a waiting period, the first day of the waiting period (typically the date employment begins).
Extended hours skilled nursing care	<p>Also referred to as private-duty nursing care, is complex nursing care services provided in a member's home.</p> <p>Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.</p>
E-Visit	An online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.
Facility	A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, or a home health agency when services are billed on a facility claim.
Family therapy	Behavioral health therapy intended to treat an individual within the context of family relationships. The focus of the treatment is to identify problems or conflicts and to set specific goals for resolving them.
Foot orthoses	Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity; protect against injury; or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.
Freestanding ambulatory surgical center	A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.

Group Home	A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.
Group therapy	Behavioral health therapy conducted with multiple patients.
Halfway house	Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.
Health care professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dietitians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
HealthPartners Administrators, Inc. (“HPAI”)	HPAI (“Claims Administrator”) is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.
HealthPartners, Inc. (“HealthPartners”)	HealthPartners is a Minnesota non-profit corporation and managed care organization. These definitions apply to the Schedule of Payments. They also apply to the SPD.
HealthPartners Trademarks	HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.
Home health agency	A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person’s home to provide health services.
Hospice care	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.
Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Illness	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
In-Network Provider	A provider that has entered into a specific network contract with the Claims Administrator or with HealthPartners. Please refer to the Benefit Chart and Coverage Information sections for network details.
Infertility testing	Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.
Inpatient Care	Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.
Intensive Outpatient Programs (IOP)	A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.
Intermittent skilled nursing care	A visit by a registered nurse or licensed practical nurse of up to four (4) consecutive hours in duration.
Intrauterine Insemination (IUI)	A specific method of artificial insemination in which semen is introduced directly into the uterus.
Investigative	<p>As determined by HealthPartners, 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. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:</p> <ol style="list-style-type: none"> 1. Whether there is 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 U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and 2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and 3. Whether there are consensus opinions of national and local health care

providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Lifetime Maximum Benefit	The specified coverage limit paid for all charges actually paid by the Plan for a covered person under that coverage. The Plan's payment ceases for that covered person, when that limit is reached. The covered person has to pay for subsequent charges. Each plan option does not have a separate lifetime maximum and covered expenses incurred under any plan option, excluding HMOs, count against the lifetime maximum. An individual does not have a new lifetime maximum when moving from one plan option to another. This means that benefits paid under all plan options with respect to an individual are counted against the lifetime maximum.
Marital/couples therapy	Behavioral health care services for the primary purpose of working through relationship issues resulting from a covered member's diagnosable mental health disorder.
Marital/couples training	Services for the primary purpose of relationship enhancements including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.
Medical emergency	Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.
Medically necessary	<p>This is health care services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by the Plan, must be:</p> <ol style="list-style-type: none">1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;2. Consistent with evidence-based standards of medical practice where applicable;3. Not primarily for your convenience or that of your family, your physician, or any other person; and4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting. <p>The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.</p>

Medicare	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.
Medicare allowed charge	<p>The charge that Medicare would authorize as the cost of a service or supply from a provider that participates in Medicare. The Medicare allowed charge is adjusted by location in the United States according to Geographic Practice Cost Indices (GPCIs) calculated by Medicare. The Medicare allowed charge for covered inpatient care is based upon the Acute Hospital Inpatient Prospective Payment System (PPS). The Medicare allowed charge does not include additional amounts, such as Disproportionate Share Hospital, Direct Graduate Medical Education, outlier amounts or other charges that are not included in the Prospective Payment System amount. Payment for physician services is based solely upon the Medicare Physician Fee Schedule.</p> <p>The determination of the allowed amount is subject to all Medicare payment rules. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or other reductions consistent with Medicare payment procedures resulting from the procedures performed and billed on the claim.</p> <p>The Medicare allowable charge that is current as of the time the services are provided will be the amount that is used in determining the allowed amount.</p>
Mental health care professional	A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders, substance abuse, or addictions.
Mental illness	A mental disorder as defined in the International Classification of Diseases. It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.
Mobile crisis services	Face-to-face short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.
Neuro-psychological examinations	Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.

Nonparticipating Provider	A provider that has not entered into a network contract with the Claims Administrator or HealthPartners.
Opioid treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Network Provider	A Participating Provider that is not In-Network; and Nonparticipating Providers.
Out-of-Pocket Expenses	You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.
Out-of-pocket limit	<p>You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter the Plan covers 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded or if the lifetime maximum is exceeded.</p> <p>Any copayments/coinsurance or deductibles you pay under the Routine Vision Feature or Prescription Drug Feature will not apply toward the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.</p> <p>The reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the Out-of-Pocket Limit. CareCheck[®] is HealthPartners' utilization review program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain benefits, as covered under the Out-of-Network Benefits of the Plan.</p> <p>HealthPartners contracts have standard provisions that will reduce benefits on out-of-network inpatient confinements. If the Covered Person fails to comply with the pre-certification requirements for an inpatient confinement, HealthPartners will reduce the eligible inpatient charges by 20%. The 20% reduction applies only to the hospital charges. The 20% reduction does not apply to deductibles, coinsurance or out-of-pockets. There is a 48-hour mandate on IP maternity, so if no authorization, the payment is not reduced 20% on the first 48 hours.</p> <p>You are responsible to keep track of the out-of-pocket expenses. Contact the HealthPartners Member Services Department at (952) 883-5144 or outside the Minneapolis/St. Paul metro area at (877) 435-7613 (toll free) for assistance in determining the amount paid by the covered person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Procedures" section of the SPD.</p>

Outpatient behavioral health treatment facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Partial programs	An intensive structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day five (5) days per week although some patients may not require daily attendance.
Participating Provider	A provider who has entered into a specific network contract with the Claims Administrator or HealthPartners.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Plan	The plan of benefits established by the Plan Administrator.
Prescription drugs	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
Pre-Service Claim	This is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only claims under this Plan that meet this definition are those claims that require pre-certification by CareCheck [®] .
Provider	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered, to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.

Qualifying creditable coverage	Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, Medicare, MinnesotaCare, Medical Assistance (Medicaid), General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan, the Children's Health Insurance Program (CHIP), or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioner of Commerce or Health.
Residential behavioral health treatment facility	A facility licensed under state law in the state in which it is located that provides treatment by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
Retail health clinic	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Semiprivate Room	A room with two (2) beds.
Services	Health care service, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.

Skilled care	Services that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.
Skilled nursing facility	A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.
Skills training	Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment and the requirements of everyday independent living.
Smoking cessation drugs	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
Substance abuse and/or addictions	Alcohol, drug dependence or other addictions as defined in the most current edition of the International Classification of Diseases.
Supervised employees	Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50 percent of each day when the employed health care professional is providing services. Independent contractors are not eligible.
Supply	Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year. Supplies do not include such things as: <ol style="list-style-type: none"> 1. alcohol swabs; 2. cotton balls; 3. incontinence liners/pads; 4. Q-tips; 5. adhesives; or 6. informational materials.

Surrogate pregnancy	An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise. Pregnancy may have been the result of conventional means, artificial insemination or assisted reproductive technologies.
Televideo conferencing	Interactive audio and video communications permitting real-time communications between a distant site health care professional and the patient whom is present and participating in the televideo visit at a remote facility.
Terminally ill patient	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
Therapeutic camps	A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.
Therapeutic day care (pre-school)	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.
Therapeutic support of foster care	Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child's improved functioning.
Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care and surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.
Waiting period	The period of time that must pass before you or your dependents are eligible for coverage under the health plan.