For Employees of:

Koochiching County

CMM HSA W/ RX

THIS HEALTH CARE PLAN IS INTENDED FOR USE WITH A FINANCIAL ACCOUNT

PLEASE READ YOUR BOOKLET CAREFULLY

Language Access Services

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

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

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

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

နမ့်ကတိၤကညီကျိုးဒီး, တၢ်ကဟ့ဉ်နၤကျိုတၢ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

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

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

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

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

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

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

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

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

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

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

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

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

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This Booklet

This booklet is a description of the principal features of your health care Plan.

Blue Cross and Blue Shield of Minnesota Member Rights and Responsibilities

You have the right as a health care Plan member to:

- be treated with respect, dignity and privacy;
- have available and accessible Medically Necessary and Appropriate Covered Services, including emergency Services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding Treatment alternatives and their risk in order to make an informed choice regardless if the health Plan pays for Treatment;
- participate with your Health Care Provider in decisions about your Treatment;
- give your Health Care Provider a health care directive or a living will (a list of instructions about health Treatments to be carried out in the event of incapacity);
- refuse Treatment;
- privacy of medical and financial records maintained by the health care Plan, the Claims Administrator and its Health Care Providers in accordance with existing law;
- receive information about the health care Plan, its Services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health care Plan, the Claims Administrator or at the clinic that you can contact with any concerns about Services;
- file an appeal with the Claims Administrator and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with the health care Plan or its providers.

You have the responsibility as a health care Plan member to:

- know your health care Plan benefits and requirements;
- provide, to the extent possible, information that the health care Plan, the Claims Administrator and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon Treatment goals;
- follow the Treatment plan prescribed by your Health Care Provider or to discuss with your provider why you are unable to follow the Treatment plan;
- provide proof of coverage when you receive Services and to update the clinic with any personal changes;
- pay Copayments at the time of Service and to promptly pay Deductibles, Coinsurance and, if applicable, charges for Services that are not covered; and,
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

Introduction

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

This booklet replaces all other certificates/booklets you have received from the Plan Administrator before the Effective Date. For purposes of this booklet, "you" or "your" refers to the Employee named on the identification (ID) card and other covered Dependents. Employee is the person for whom the Employer has provided coverage. Dependent is a covered Dependent of the Employee.

The Plan Administrator has contracted with the Claims Administrator to provide coverage for its Employees and their Dependents. Terms are defined in the "Terms You Should Know" section.

This booklet explains the health care Plan, eligibility, notification procedures, Covered Services, and expenses that are not covered. It is important that you read this entire booklet carefully. If you have questions about your coverage, please call Member Service at the telephone number listed on the back of your member ID card or log onto your Blue Cross member website at www.bluecrossmnonline.com.

This Plan, financed and administered by Koochiching County, is a self-insured medical Plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the Claims Administrator and provides administrative Services only. The Claims Administrator does not assume any financial risk or obligation with respect to Claims. Coverage is subject to all terms and conditions of this booklet, including Medical Necessity and Appropriateness.

This Plan is not subject to ERISA.

If you have any questions on your health care Plan, please call Member Service at the telephone number listed on the back of your member ID card.

How Your Benefits Are Applied

To help you understand your coverage and how it works, here is an explanation of some benefit terms found in your "Summary of Benefits" section.

Benefit Period

The specified period of time during which charges for Covered Services must be incurred in order to be eligible for payment by the health care Plan. A charge shall be considered incurred on the date you receive the Service or Supply for which the charge is made.

Your group's benefit period is based on a Calendar Year. The Calendar Year is January 1 to December 31.

Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for Covered Services. The terms "Copayment," "Deductible" and "Coinsurance" describe methods of such payment that may apply to your Plan.

You must notify the Claims Administrator regarding any discounts, coupons, coupon cards, point of service rebates, debit cards, or other forms of financial arrangements between you and a Provider or manufacturer for health care items or medical Services (hereinafter referred to as "Coupons"). The dollar amount of any Coupon provided to you by Providers or manufacturers will not count toward Coinsurance, Copayment, or Deductible cost-sharing responsibilities or Out-of-Pocket Limit.

Coinsurance

The Coinsurance is the specific percentage of the Allowed Amount for Covered Services that is your responsibility. Refer to the Plan Payment Level in your "Summary of Benefits" section for the Coinsurance percentage amounts.

Copayment

The Copayment for certain Covered Services is the specific, upfront dollar amount which will be deducted from the Allowed Amount by the Claims Administrator and is your responsibility. See your "Summary of Benefits" section for applicable Copayment amounts.

Deductible

The Deductible is a specified dollar amount you must pay for most Covered Services each Calendar Year before the health care Plan begins to provide payment for benefits. Services such as prenatal care, Pediatric Preventive Care, and Primary Network Preventive Care Services for adults are not subject to the Deductible. See the "Summary of Benefits" section for the Deductible amount.

Out-of-Pocket Limit

The Out-of-Pocket Limit refers to the specified dollar amount of member cost-sharing incurred for Covered Services in a Calendar Year. When the specified dollar amount is attained, the health care Plan begins to pay 100% of the Allowed Amount for all covered expenses. See your "Summary of Benefits" section for the Out-of-Pocket Limit.

Maximum

The greatest amount of benefits that the health care Plan will provide for Covered Services within a prescribed period of time. This could be expressed in dollars, number of days, number of visits, or number of Services.

Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses. The following provision(s) describe the methods of such payment that may apply to your Plan.

You must notify the Claims Administrator regarding any discounts, coupons, coupon cards, point of service rebates, debit cards, or other forms of financial arrangements between you and a Provider or manufacturer for Prescription Drugs and/or devices (hereinafter referred to as "Coupons"). The dollar amount of any Coupon provided to you by Providers or manufacturers will not count toward your Coinsurance, Copayment, or Deductible cost-sharing responsibilities or Out-of-Pocket Limit.

Copayment

The Copayment is the specific, upfront dollar amount you pay for covered medications which will be deducted from the provider's Allowed Amount. The applicable Copayment obligation is the amount specified in the "Summary of Benefits" section, or the cost of the covered medication, whichever is lower.

Coinsurance

The Coinsurance is the specific percentage of the Allowed Amount for covered medications that is your responsibility. Refer to the Plan Payment Level in your "Summary of Benefits" section for applicable Coinsurance percentage amounts.

Deductible

The Deductible is a specified dollar amount you must pay for covered medications each Calendar Year before the health care Plan begins to provide payment for benefits. See the "Summary of Benefits" section for the Deductible amount.

Out-of-Pocket Limit

The Out-of-Pocket Limit refers to the specified dollar amount of member cost-sharing incurred for covered medications in a Calendar Year. When the specified dollar amount is attained, the health care Plan begins to pay 100% of the Allowed Amount for all covered expenses. See your "Summary of Benefits" section for the Out-of-Pocket Limit.

Summary of Benefits

This Summary of Benefits outlines your Covered Services. More details can be found in the "Covered Services" section.

Networks	
Your provider directory lists Network Providers in our Service area and may change from time to time, including as providers or Blue Cross initiate or terminate network contracts. Prior to receiving Services, it is recommended that you verify your Provider's network status with Blue Cross, including whether the Provider is Network for your particular plan. Not every Provider is Network for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Sign in" then "Find a Doctor") or contact Member Service at the telephone number listed on your member ID card.	
• Network Providers	
▪ In Minnesota	Aware Network Providers
▪ Outside Minnesota	BlueCard Traditional Network Providers

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
The health care Plan's benefit period is based on a Calendar Year. The Calendar Year is January 1 to December 31.		
Deductible including Pharmacy		
• Individual	$2,700	
• Family	$5,400	
Deductible - Embedded For a family with covered Dependents, the Deductible you pay for all covered family members, regardless of family size, is specified under family Deductible. To reach this total, you can count the expenses incurred by one or more covered family members. However, the Deductible contributed towards the total by any one covered family member will not be more than the amount of the individual Deductible. If one family member meets the individual Deductible and needs to use benefits, the health care Plan would begin to pay for that member's Covered Services even if the Deductible for the entire family has not been met.		
Plan Payment Level - Based on the Allowed Amount	Generally, 100% after Deductible until Out-of-Pocket Limit is met; then 100%	Generally, 80% after Deductible until Out-of-Pocket Limit is met; then 100%
Out-of-Pocket Limits - eligible medical Services including Pharmacy		
• Individual	$2,700	$3,500
• Family	$5,400	$6,500
The amounts accumulated toward the Out-of-Network Out-of-Pocket Limit are also accumulated toward the Network Out-of-Pocket Limit. When the Out-of-Network Out-of-Pocket Limit is satisfied, both Network and Out-of-Network Out-of-Pocket Limits are considered satisfied and covered Services from all providers are paid at 100% of the Allowed Amount.		

Benefits	Network	Out-of-Network
Lifetime Maximum (per member) • Assisted Fertilization ▪ all Services combined (medical and Prescription Drugs)	$10,000	
• Travel expenses for Living Donor Kidney Transplants to a Mayo Designated Transplant Provider only	$5,000	
• Travel expenses for Transplants in a Blue Distinction Center only	$5,000	
• Total benefits paid to all other providers combined	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Health Clinic Visits		
• Office visit	100% after Deductible	80% after Deductible
• Lab Services	100% after Deductible	80% after Deductible
• All other professional Services	100% after Deductible	80% after Deductible
Physician		
• Office visits	100% after Deductible	80% after Deductible
• Office lab Services	100% after Deductible	80% after Deductible
• Outpatient lab Services	100% after Deductible	80% after Deductible
• Office diagnostic imaging Services	100% after Deductible	80% after Deductible
• Outpatient diagnostic imaging Services	100% after Deductible	80% after Deductible
• E-Visit	100% after Deductible	80% after Deductible
• Professional billed Services received at a free-standing ambulatory surgical center	100% after Deductible	80% after Deductible
• All other professional Services	100% after Deductible	80% after Deductible
• OMADA program for members age 18 or older for pre-diabetes and high risk cardiac	100%	NO COVERAGE
• OMADA delivers a pre-diabetes and high risk cardio vascular prevention program. Members age 18 and older may participate in a curriculum (aka OMADA program) with digital tools to track improvement in diet, physical activity, and weight loss in a pre-diabetic/high risk cardiac population.		

Benefits	Network	Out-of-Network
Specialist		
• Office visits	100% after Deductible	80% after Deductible
• Office lab Services	100% after Deductible	80% after Deductible
• Outpatient lab Services	100% after Deductible	80% after Deductible
• Office diagnostic imaging Services	100% after Deductible	80% after Deductible
• Outpatient diagnostic imaging Services	100% after Deductible	80% after Deductible
• E-Visit	100% after Deductible	80% after Deductible
• Professional billed Services received at a free-standing ambulatory surgical center	100% after Deductible	80% after Deductible
• All other professional Services	100% after Deductible	80% after Deductible
• OMADA program for members age 18 or older for pre-diabetes and high risk cardiac	100%	NO COVERAGE
• OMADA delivers a pre-diabetes and high risk cardio vascular prevention program. Members age 18 and older may participate in a curriculum (aka OMADA program) with digital tools to track improvement in diet, physical activity, and weight loss in a pre-diabetic/high risk cardiac population.		
Urgent Care Center Visits		
• Professional Urgent Care Services ▪ professional office visit for Urgent Care	100% after Deductible	80% after Deductible
▪ professional lab Services for Urgent Care	100% after Deductible	80% after Deductible
▪ professional diagnostic imaging Services for Urgent Care	100% after Deductible	80% after Deductible
▪ all other professional Services for Urgent Care	100% after Deductible	80% after Deductible
• Facility Urgent Care Services, except as noted below	100% after Deductible	80% after Deductible
▪ Facility lab Services for Urgent Care	100% after Deductible	80% after Deductible
▪ Facility diagnostic imaging Services for Urgent Care	100% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
Preventive Care Services		
Adults and children age 6 and older		
• Routine physical exams	100%	80% after Deductible
• Adult Immunizations	100%	80% after Deductible
• Diagnostic Services and procedures	100%	80% after Deductible
• Routine gynecological exams, including a PAP Test	100%	80% after Deductible
• Mammograms, annual routine and Medically Necessary and Appropriate	100%	80% after Deductible
• Colorectal Cancer Screening	100%	80% after Deductible
• Preventive Care Services are limited to those on the health care Plan's Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.		
Pediatric		
• Routine physical exams from birth to age 6	100%	100%
• Pediatric immunizations from birth to age 18	100%	100%
• Diagnostic Services and procedures from birth to age 6	100%	100%
• Pediatric Preventive Care Services are limited to those on the health care Plan's Preventive Schedule. Gender, age and frequency limits may apply.		
Hospital Inpatient Services		
• Inpatient Hospital/Facility Services	100% after Deductible	80% after Deductible
Living Donor Kidney Transplant Services	100% of the Transplant Payment Allowance after Deductible for the transplant Admission when you use a Mayo Designated Transplant Provider	NO COVERAGE
• There may be a benefit available for travel expenses directly related to a preauthorized Living Donor Kidney Transplant. Please contact Member Service at the telephone number on the back of your member ID card for further information. Restrictions apply.		
Hospital Outpatient Services		
• Outpatient Hospital/Facility Services, except as noted below	100% after Deductible	80% after Deductible
• Lab Services	100% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
• Diagnostic imaging Services	100% after Deductible	80% after Deductible
• Facility billed free-standing ambulatory surgical center Services	100% after Deductible	80% after Deductible
Maternity		
• Prenatal Hospital/Facility provider Services	100%	Same as Network Services
• Prenatal professional Services	100%	Same as Network Services
• Inpatient Hospital/Facility provider Services for: ▪ delivery in a Hospital/Facility ▪ postpartum care	100% after Deductible	80% after Deductible
• Professional Services for: ▪ delivery in a Hospital/Facility	100% after Deductible	80% after Deductible
▪ postpartum care • office visit	100% after Deductible	80% after Deductible
• all other eligible Services	100% after Deductible	80% after Deductible
Emergency Services		
• Facility charges	100% after Deductible	Same as Network Services
• Professional charges	100% after Deductible	Same as Network Services
• Eligible Services you receive from Out-of-Network Providers apply to the Network Out-of-Pocket Limit.		
Ambulance		
• Emergency Medically Necessary and Appropriate Services from the place of departure to the nearest medical Facility equipped to treat the condition	100% after Deductible	Same as Network Services
• Non-emergency Medically Necessary and Appropriate Services from the place of departure to nearest medical Facility equipped to treat the condition	100% after Deductible	Same as Network Services
• Eligible Services you receive from Out-of-Network Providers apply to the Network Out-of-Pocket Limit.		
Therapy and Rehabilitation Services		
Occupational Therapy		
• Habilitative and rehabilitative office visits	100% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
• Habilitative and rehabilitative therapies	100% after Deductible	80% after Deductible
Physical Therapy		
• Habilitative and rehabilitative office visits	100% after Deductible	80% after Deductible
• Habilitative and rehabilitative therapies	100% after Deductible	80% after Deductible
Speech Therapy		
• Habilitative and rehabilitative office visits	100% after Deductible	80% after Deductible
• Habilitative and rehabilitative therapies	100% after Deductible	80% after Deductible
Chiropractic Services		
• Spinal Manipulations - includes office visit	100% after Deductible	80% after Deductible
• Other chiropractic Services including therapies	100% after Deductible	80% after Deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services		
• Inpatient professional Services	100% after Deductible	80% after Deductible
• Inpatient Hospital/Residential Behavioral Health Treatment Facility Services	100% after Deductible	80% after Deductible
• Outpatient Professional Services ▪ office visit	100% after Deductible	80% after Deductible
▪ all other professional Services – office/clinic	100% after Deductible	80% after Deductible
▪ all other professional Services – outpatient Hospital/Facility	100% after Deductible	80% after Deductible
• Outpatient Hospital/Facility Services	100% after Deductible	80% after Deductible
Substance Abuse Services		
• Inpatient professional Services	100% after Deductible	80% after Deductible
• Inpatient Hospital/Residential Behavioral Health Treatment Facility Services	100% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
• Outpatient professional Services ▪ office visit	100% after Deductible	80% after Deductible
▪ all other professional Services	100% after Deductible	80% after Deductible
• Outpatient Facility Services	100% after Deductible	80% after Deductible
Other Services		
• Acupuncture Services for the Treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	100% after Deductible	80% after Deductible
• Eligible acupuncture Services are limited to 20 visits per member per Calendar Year all Providers combined.		
Durable Medical Equipment		
• Durable Medical Equipment, except as noted below	100% after Deductible	80% after Deductible
• Orthotics	100% after Deductible	80% after Deductible
• Insulin pumps, glucometers, and related equipment and devices	100% after Deductible	80% after Deductible
• Custom Foot Orthoses if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet	100% after Deductible	80% after Deductible
• Prosthetics	100% after Deductible	80% after Deductible
Home Infusion and Suite Infusion Therapy Services	100% after Deductible	NO COVERAGE
Home Health Care	100% after Deductible	80% after Deductible
Hospice	100% after Deductible	NO COVERAGE
Assisted Fertilization	100% after Deductible	80% after Deductible
• Assisted Fertilization Services are subject to a Lifetime maximum limit of $10,000 per member for medical Services and Prescription Drugs combined.		
Skilled Nursing Facility Care	100% after Deductible	80% after Deductible
• Skilled Nursing Facility Care is subject to a maximum of 120 days per member per Calendar Year.		
Transplant Services	100% of the Transplant Payment Allowance after Deductible for the transplant Admission when you use a Blue Distinction Centers for Transplant (BDCT) Provider	80% of the Transplant Payment Allowance after Deductible when you use a Participating Transplant Provider NO COVERAGE when you use a Nonparticipating Provider

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

Prescription Drug Benefits	Retail Pharmacy Up to 31-day Supply	Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy Up to 90-day Supply	Nonparticipating Retail Pharmacy
Pharmacy Network	Classic Pharmacy Network	Participating: 90dayRx Retail and Mail Service Pharmacy	Nonparticipating Pharmacy
• **GenRx Preferred Generic Prescription Drugs**	0% Coinsurance after Deductible	**90dayRx Participating Retail Pharmacy:** 0% Coinsurance after Deductible **Mail Service Participating Pharmacy:** 0% Coinsurance after Deductible	0% Coinsurance after Deductible
• **GenRx Preferred Brand Prescription Drugs**	0% Coinsurance after Deductible	**90dayRx Participating Retail Pharmacy:** 0% Coinsurance after Deductible **Mail Service Participating Pharmacy:** 0% Coinsurance after Deductible	0% Coinsurance after Deductible
• **Retail Pharmacy Vaccine program** ▪ certain eligible vaccines administered at a participating Retail Pharmacy	0% Coinsurance	NO COVERAGE	NO COVERAGE
Preventive Medications			
• **Affordable Care Act (ACA) Preventive Covered Prescription Drugs**	0% Coinsurance Deductibles, Coinsurance and/or Copayments do not apply	0% Coinsurance Deductibles, Coinsurance and/or Copayments do not apply	0% Coinsurance Deductibles, Coinsurance and/or Copayments do not apply
▪ FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. ▪ Designated preventive drugs with a prescription (such as FDA-approved Tobacco Cessation Drugs and Products, aspirin, folic acid, vitamin D, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.			
• Preventive Covered Prescription Drugs and over-the-counter drugs that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Covered Services - Prescription Drug Program section for more information.			

Covered Services - Medical Program

The health care Plan provides coverage of benefits for the following Services you receive from a provider when such Services are determined to be Medically Necessary and Appropriate. All benefit limits, Deductibles and Copayment amounts are described in the "Summary of Benefits" section. Network care is covered at a higher level of benefits than Out-of-Network care.

Ambulance Service

Ambulance Service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or Medical Emergency to a Hospital or Skilled Nursing Facility provider;
- between Hospitals; or
- between a Hospital and a Skilled Nursing Facility provider;

when such Facility provider is the closest institution that can provide Covered Services appropriate for your condition. If there is no Facility provider in the local area that can provide Covered Services appropriate for your condition, then ambulance Service means transportation to the closest Facility provider outside the local area that can provide the necessary Service.

Transportation and related emergency Services provided by an ambulance Service will be considered emergency ambulance Service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance Services. Refer to the "Terms You Should Know" section for a definition of Medical Emergency.

Benefits include non-emergency Medically Necessary and Appropriate prearranged or scheduled Ambulance Service requested by an attending Physician or nurse from the place of departure to the closest Facility provider that can provide the necessary Service.

No ambulance benefits will be paid for:

- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical Facility equipped to treat the condition (Example: Facility A is the closest medical Facility equipped to treat the condition but you choose to be transported to Facility B. We will cover eligible Medically Necessary and Appropriate ambulance transportation costs that would otherwise apply to transportation to Facility A. If you choose to be transported by ambulance to Facility B, the cost of transportation Services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to Facility A are not covered under the Plan, and you will be responsible for those costs)**.**

Anesthesia for Non-Covered Dental Procedures (Limited)

The health care Plan covers anesthesia and inpatient and outpatient Hospital charges when necessary to provide Dental Care 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 Hospital/Facility provider charges please refer to "Hospital Services." Dental Services are not covered unless otherwise noted.

Autism Spectrum Disorders

Benefits are provided for autism Treatment, including intensive behavioral therapy programs for the Treatment of Autism Spectrum Disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.

Diabetes Treatment

Coverage is provided for the following when required in connection with the Treatment of diabetes and when prescribed by a Health Care Provider legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices

- Diabetes Education Program*: When your Health Care Provider certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
  - Visits Medically Necessary and Appropriate upon the diagnosis of diabetes
  - Subsequent visits under circumstances whereby your Physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to your Treatment and/or management of diabetes

*__Diabetes Education Program -__ an outpatient program of self-management, training and education, including medical nutrition therapy, for the Treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed Health Care Provider with expertise in diabetes.

Diagnostic Services

Benefits will be provided for the following Covered Services when ordered by a Health Care Provider:

- Diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the Claims Administrator
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, upon approval by the Claims Administrator, the purchase, adjustment, repairs and replacement of Durable Medical Equipment for therapeutic use when prescribed by a Health Care Provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.

Special dietary Treatment for Phenylketonuria (PKU) when recommended by a Physician.

Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.

Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per member per Calendar Year.

You are required to obtain Prior Authorization for Durable Medical Equipment when you use Nonparticipating Providers in Minnesota or any Provider outside of Minnesota. Please refer to www.bluecrossmnonline.com (choose the "Providers" tab in the lower left corner, then the "Medical Policy" tab under "Tools and Resources") or call Member Service at the telephone number on the back of your member ID card.

Home Health Care/Hospice Care Services

This health care Plan covers the following Services you receive from a Home Health Care Agency, Hospice or a Hospital program for Home Health Care and/or Hospice Care:

- Home Health Care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.
- Skilled Nursing Services - Intermittent Hours of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Physical therapy, speech therapy and occupational therapy
- Medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care or Hospice Care
- Services provided by a medical technologist

- Services provided by a respiratory therapist
- Services provided by a licensed registered dietician
- Oxygen and its administration
- Medical social Service consultations by a masters level social worker
- Health aide Services when you are also receiving covered nursing Services or therapy and rehabilitation Services
- Family counseling related to the member's terminal condition
- Palliative Care
- Hospice benefits are limited to members with a terminal condition (i.e., life expectancy of six (6) months or less). The member'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.
- Hospice program inpatient Respite Care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- Hospice program general Inpatient Care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical Services unrelated to the terminal condition under the hospice program are covered but are separate from the hospice benefit.

No Home Health Care/Hospice benefits will be provided for:

- room and board expenses in a residential hospice Facility provider;
- homemaker Services;
- Maintenance Services;
- dialysis Treatment;
- Custodial Care; and
- food or home-delivered meals.

Home Infusion and Suite Infusion Therapy Services

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, pharmacy Services, intravenous solutions, medical/surgical supplies and nursing Services associated with infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

Hospital Services

This health care Plan covers the following Services received in a Facility provider. Benefits will be covered only when, and so long as, they are determined to be Medically Necessary and Appropriate for the Treatment of the member's condition.

The Plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant, please refer to "Transplant Coverage." You also have the option for benefits for Living Donor Kidney Transplant Services provided by Mayo Clinic. Please refer to "Hospital Inpatient Services" in the "Summary of Benefits" section and below in this section for additional information.

Inpatient Services

Bed and Board

Bed, board and general nursing Services are covered when you occupy:

- a Hospital room and board;

- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive Services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital Services and supplies including, but not restricted to:

- The health care Plan covers anesthesia inpatient Hospital charges when necessary to provide Dental Care 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. Dental Services are not covered unless otherwise noted;
- Communication Services of a private-duty nurse or personal care assistant up to 120 hours per Hospital Admission;
- use of operating, delivery and Treatment rooms and equipment;
- Prescription Drugs and medicines provided to you while you are an inpatient in a Facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and Services rendered in a Facility provider by an employee of the Facility provider. Administration of anesthesia ordered by the Attending Health Care Provider and rendered by a Health Care Provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;
- Telemedicine Services;
- diagnostic Services;
- Living Donor Kidney Transplant Services; and
- therapy and rehabilitation Services.

There may be a benefit available for travel expenses directly related to a preauthorized Living Donor Kidney Transplant. Please contact Member Services at the telephone number on the back of your member ID card for further information. Restrictions apply.

Outpatient Services

Ancillary Services

Hospital Services and supplies including, but not restricted to:

- anesthesia and outpatient Hospital charges when necessary to provide Dental Care to a member who is a child under age five (5); is severely disabled; or, has a medical condition that requires Hospitalization or general anesthesia for dental Treatment. Dental Services are not covered unless otherwise noted.
- use of operating, delivery and Treatment rooms and equipment;
- Prescription Drugs and medicines provided to you while you are outpatient in a Facility;
- the surgeon or assistant at surgery;
- Telemedicine Services; and
- medical and surgical dressings, supplies, casts and splints.

Pre-Admission Testing

Tests and studies required in connection with your Admission rendered or accepted by a Hospital on an outpatient basis prior to a scheduled Admission to the Hospital as an inpatient.

Surgery

- Hospital Services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and Services rendered by an employee of the Facility provider, other than the surgeon or assistant at surgery;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and Services rendered in a Facility provider by an employee of the Facility provider. Administration of anesthesia ordered by the Attending Health Care Provider and rendered by a Health Care Provider other than the surgeon or assistant at surgery.

Emergency Care Services

As a member, you are covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately.*

Your outpatient emergency room visits may be subject to a Copayment. (Refer to the "Summary of Benefits" section for your health care Plan's specific amounts.)

In true emergency situations, where you must be treated immediately, go directly to your nearest Hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a Medical Emergency the Claims Administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.

Once the crisis has passed, call your Physician to receive appropriate follow-up care.

Refer to the "Terms You Should Know" section for a definition of emergency care Services.

Maternity Services

If you think you are pregnant, you may contact your Physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, Medically Necessary and Appropriate sonograms, delivery, postpartum and newborn care in the Hospital.

Hospital, medical and surgical Services rendered by a Facility provider or professional provider for:

Prenatal Care

The comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Complications of Pregnancy

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Normal Pregnancy

Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Nursery Care

Covered Services provided to the newborn child from the moment of birth, including care which is necessary for the Treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. To be covered as a Dependent, the newborn child must be enrolled as a Dependent under this health care Plan. Refer to the "General Information" section for further eligibility information. Please refer to the "Eligibility" section to determine when the newborn's coverage will begin if the newborn is added to the health care Plan.

Maternity Home Health Care Visit

Under federal law, group health Plans such as this health care Plan are required to provide benefits for any Hospital length of stay in connection with childbirth as follows:

- Inpatient Hospital coverage for the mother and newborn (to the extent they are covered under this health care Plan) is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) Home Health Care visit within four (4) days after discharge from the Hospital is covered under this health care Plan. Refer to "Home Health Care."

Under federal law, the health care Plan may require that a provider obtain authorization from the health care Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.

Medical Dental Services

Accident related Dental Services

Accident-related dental Services, Treatment and/or restoration of a sound and health natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this Plan. Coverage is limited to the initial Treatment (or course of Treatment) and/or initial restoration. Only Services performed within 24 months from the date of Treatment or restoration is initiated are covered. Coverage for Treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.

Temporomandibular Joint Disorder (TMJ)

Services for surgical and nonsurgical Treatment of temporomandibular joint disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a Physician or dentist.

Cleft Lip and Palate

Treatment of cleft lip and palate when Services are scheduled or initiated prior to the member turning age 19 including:

- dental implants
- removal of impacted teeth or tooth extractions
- related orthodontia
- related oral surgery
- bone grafts

Medical Services

For members diagnosed with end stage renal disease (ESRD), your Provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form 2728 ESRD Evidence Report Medicare Entitlement and/or Patient Registration. Your Provider must send the completed form to CMS and Blue Cross. Please verify with your Provider that form 2728 has been completed and submitted.

The Plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant, please refer to "Transplant Coverage." You also have the option for benefits for Living Donor Kidney Transplant Services provided by Mayo Clinic. Please refer to "Hospital Inpatient Services" in the "Summary of Benefits" section and below in this section for additional information.

Inpatient Medical Services

Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or Mental Illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for Treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate Physicians.

Consultation

Consultation Services rendered to an inpatient by another professional provider at the request of the Attending Health Care Provider. Consultation does not include staff consultations which are required by Facility provider rules and regulations.

Inpatient Medical Care Visits

Benefits are provided for inpatient medical care visits.

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and Treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or Mental Illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and Treatment of an injury or Illness.

Please note that as a member, you enjoy many convenient options for where you can receive Outpatient Care:

- Physician's or Specialist's office
- Physician's office located in an outpatient Hospital/Hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store
- Telemedicine Services

An E-Visit is a member patient initiated, limited online evaluation and management health care Service provided by a Physician or other qualified Health Care Provider using the internet or similar secure communications network to communicate with an established member patient.

Telemedicine Services may also be referred to as televideo consultations or telehealth Services. These Services are interactive audio and video communications, permitting real-time communication between a distant site Physician or practitioner and the member, who is present and participating in the televideo visit at a remote Facility.

For self-administered prescription medications/drugs, please refer to "Prescription Drugs," except as provided in Medical Policy.

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Plan benefits.

The health care Plan covers Treatment of diagnosed Lyme disease on the same basis as any other Illness.

You are entitled to receive care for the following Services at the Network level from Out-of-Network Providers if these Services are covered under your health care Plan:

- the voluntary planning of the conception and bearing of children;
- the diagnosis of Infertility;
- the testing and Treatment of a sexually transmitted disease; or,
- the testing of AIDS or other HIV-related conditions.

The health care Plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and Services that would be covered for members who are not enrolled in an approved clinical trial.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections including testing and serum.

Therapeutic Injections

Therapeutic injections administered by a Health Care Provider required in the diagnosis, prevention and Treatment of an injury or Illness.

Mental Health Care Services

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

You are covered for a full range of counseling and Treatment Services. The health care Plan covers the following Services you receive from a provider to treat Mental Illness:

Inpatient Facility Services

Inpatient Hospital Services provided by a Facility provider for the Treatment of Mental Illness.

Coverage is provided for Treatment of emotionally disabled Dependent children in a licensed Residential Behavioral Health Treatment Facility. "Emotionally disabled child" shall have the meaning set forth by the Minnesota Commissioner of Human Services in the rules relating to residential treatment facilities.

Inpatient Medical Services

Covered inpatient medical Services provided by a Health Care Provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in your diagnosis and Treatment

Partial Hospitalization Mental Health Care Services

Benefits are only available for mental health care Services provided on a Partial Hospitalization basis when received through a Partial Hospitalization program. A mental health care Service provided on a Partial Hospitalization basis will be deemed an Outpatient Care visit and is subject to any Outpatient Care cost-sharing amounts.

Outpatient Mental Health Care Services

Inpatient Facility Service and inpatient medical benefits (except room and board) provided by a Facility provider or professional provider as previously described, are also available when you are an outpatient.

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 and Appropriate.

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. Court-ordered Treatment that does not meet the criteria above will be covered if it is determined to be Medically Necessary and Appropriate and otherwise covered under this health care Plan.

Benefits are provided for autism Treatment, including intensive behavioral therapy programs for the Treatment of Autism Spectrum Disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (EIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.

Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered Medically Necessary and Appropriate for the entire hold.

Serious Mental Illness Care Services

Serious Mental Illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

Coverage is provided for Inpatient Care and Outpatient Care for the Treatment of serious Mental Illness. A serious Mental Illness Service provided on a Partial Hospitalization basis will be deemed to be an Outpatient Care visit subject to any Outpatient Care cost-sharing amounts.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Custom Foot Orthoses are covered if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Preventive Care 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 "Summary of Benefits" and "Covered Services – Medical Program: Hospital Services and Medical Services," etc. for appropriate benefit levels.

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors which are the recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA). The Claims Administrator periodically reviews the schedule of Covered Services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP and HRSA. Therefore, the frequency and eligibility of Services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of Covered Services, log onto the Claims Administrator’s member website at, www.bluecrossmnonline.com or call Member Service at the telephone number listed on the back of your member ID card.

Benefits for Services identified as Preventive Care are determined based on recommendations and criteria established by professional associations and experts in the field of Preventive Care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), etc.). For all other eligible Services, please refer to "Hospital Services," and "Medical Services."

Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage please visit www.bluecrossmnonline.com ("Member Sign In" then "Plan Details"/"Preventive care benefit information"/"learn more") or contact Member Service.

Benefits are provided for the full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Please refer to "Prescription Drugs and Insulin" for outpatient drug coverage.

Services for complications related to female contraceptive drugs, devices, and Services for women of reproductive capacity may be covered under other Plan benefits. Please refer to "Hospital Inpatient," "Hospital Outpatient," "Physician Services," etc. for appropriate benefit levels.

Adult and Pediatric Care

Routine physical examinations including a complete medical history for adults, and other items and Services.

Well-woman benefits are provided for female members for items and Services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.

Benefits are provided for "child health supervision Services," which means pediatric preventive Services, appropriate immunizations, developmental assessments, and laboratory Services appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics.

Adult Immunizations

Benefits are provided for adult immunizations that require administration by a Health Care Provider, including the immunizing agent, when required for the prevention of disease.

Diagnostic Services and Procedures

Benefits are provided for the following routine screening tests and procedures:

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for routine gynecological examinations, including a pelvic and clinical breast examination, and Papanicolaou smear (Pap test).

Mammogram Screening

Benefits are provided for a routine mammogram screening for all female members.

Pediatric Immunizations

Benefits are provided to eligible Dependent children for pediatric immunizations.

Colorectal Cancer Screenings

Benefits are provided for the following tests or procedures when ordered by a Physician for the purpose of early detection of colorectal cancer:

- Diagnostic laboratory and pathology screening Services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic imaging screening Services such as barium enema
- Surgical screening Services such as flexible sigmoidoscopy and colonoscopy and Hospital Services related to such surgical screening Services
- Such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening Services consistent with approved medical standards and practices for the detection of colon cancer

If you are determined to be at high or increased risk, benefits are provided for a colonoscopy or any other combination of Covered Services related to colorectal cancer screening when prescribed by a Physician.

Colorectal cancer screening Services which are otherwise not described herein and are prescribed by a Physician for a symptomatic member are not considered preventive care Services. The payment for these Services will be consistent with similar Medically Necessary and Appropriate Covered Services.

Prostate Specific Antigen (PSA) tests

- Prostate Specific Antigen (PSA) tests, digital rectal exams.

Surveillance tests for ovarian cancer

- Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam).

Skilled Nursing Facility Services

Skilled Care ordered by a Physician, including room and board, general nursing care, Prescription Drugs used during a covered Admission, and physical, occupational and speech therapy.

No benefits are payable:

- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive Treatment other than routine supportive care;
- when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience.

Spinal Manipulations

Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the Treatment of Substance Abuse and include the following:

- Inpatient Hospital or Substance Abuse Treatment Facility provider Services for detoxification.
- Substance Abuse Treatment Facility provider Services for non-Hospital inpatient residential Treatment and Rehabilitation Services.
- Outpatient Hospital or Substance Abuse Treatment Facility provider or outpatient Substance Abuse Treatment Facility provider Services for rehabilitation therapy.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered Medically Necessary and Appropriate for the entire hold.
- Court-ordered Treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections.

For purposes of this benefit, a Substance Abuse Service provided on a Partial Hospitalization basis shall be deemed an Outpatient Care visit and is subject to any Outpatient Care cost-sharing amounts.

Surgical Services

This health care Plan covers the following Services you receive from a professional provider. See the Healthcare Management section for additional information which may affect your benefits.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the Attending Health Care Provider and rendered by a Health Care Provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the Attending Health Care Provider.

Assistant at Surgery

Services of a Physician or Medically Necessary and Appropriate Services of a registered nurse first assistant who actively assists the operating surgeon in the performance of covered surgery.

Surgery

- Sterilization (please refer to Preventive Care for female sterilization)
- Surgery performed by a professional provider. Separate payment will not be made for pre-operative and post-operative Services
- Reconstructive surgery performed on a Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the Attending Health Care Provider. Congenital means present at birth.
- Elimination or maximum feasible Treatment of port wine stains.

- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where the Claims Administrator deems that an additional allowance is warranted.

Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and Appropriate:

- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
- Facility provider and anesthesia Services rendered in a Facility provider setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and Appropriate due to your age and/or medical condition
- Accident-related dental Services from Physician or dentist for the Treatment of an injury to sound and healthy natural teeth if the Treatment begins within 12 months of either the date of the injury or first date of coverage and is completed within 24 months of the first Treatment
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

Therapy and Rehabilitation Services

This health care Plan covers the following Services when such Services are ordered by a Physician:

- Cardiac rehabilitation
- Chemotherapy
- Dialysis Treatment
- Occupational therapy
- Physical therapy
- Radiation therapy
- Respiratory therapy
- Speech therapy

Transplant Services

Benefits may be provided for Covered Services furnished by a Hospital which are directly and specifically related to the transplantation of the following human organs, bone marrow, cord blood and peripheral stem cells (refer to the "Summary of Benefits" section above for information about how transplant Services may be covered):

For members diagnosed with end stage renal disease (ESRD), your Provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form 2728 ESRD Evidence Report Medicare Entitlement and/or Patient Registration. Your Provider must send the completed form to CMS and Blue Cross. Please verify with your Provider that form 2728 has been completed and submitted.

The following Medically Necessary and Appropriate human organ, bone marrow, cord blood and peripheral blood stem cell transplant procedures:

- Allogeneic and syngeneic bone marrow transplant and peripheral blood stem cell and umbilical cord blood transplant procedures
- Autologous bone marrow transplant and peripheral blood stem cell transplant procedures
- Heart
- Heart-lung
- Kidney - pancreas transplant performed simultaneously (SPK)
- Liver - deceased donor and living donor
- Liver-kidney
- Lung - single or double

- Pancreas transplant - deceased donor and living donor segmental
  - Pancreas transplant alone (PTA)
  - Simultaneous pancreas - kidney transplant (SPK)
  - Pancreas transplant after kidney transplant (PAK)
- Small-bowel and small-bowel/liver

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of their health care Plan;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care Plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this health care Plan to the extent that benefits remain and are available under this health care Plan after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this health care Plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this health care Plan; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's health care Plan limit.
- if you live more than 50 miles from a BDCT Provider, there may be a travel benefit available for expenses directly related to a preauthorized transplant.
- eligible transplant Services provided by Participating Transplant Providers will be paid at the Blue Distinction Centers for Transplant (BDCT) Providers level of benefits when the transplant Services are not available at a BDCT Provider.

Under the Transplant Services benefit there are no benefits payable for:

- 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.

Covered Services - Prescription Drug Program

Eligible Prescription Drugs are covered when you purchase them through the pharmacy network applicable to your health care Plan and nonparticipating pharmacies, except as provided herein . Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day. For convenience and choice, network pharmacies include both major chains and independent stores.

Blue Cross chooses which drugs are on its Drug Lists, or excluded from its Drug Lists, based on numerous factors including their quality, safety and effectiveness, and overall cost. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a Drug List while the generic of the same drug is excluded from a Drug List.

The Blue Cross Prescription Drug List is an extensive list of Food & Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Cross Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee.

A **Retail Pharmacy** is a licensed pharmacy that you can physically enter to obtain a Prescription Drug. Eligible Prescription Drugs and diabetic supplies are generally covered up to a 31-day Supply.

90dayRx includes the following: A Retail Pharmacy participating in the 90dayRx Network and a participating Mail Service Pharmacy that dispenses Prescription Drugs through the U.S. Mail. Eligible Prescription Drugs are dispensed up to a 90-day authorized Supply of ongoing, long-term Prescription Drugs.

Covered Prescription Drugs

Covered Prescription Drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend Prescription Drugs under applicable state law and dispensed by a licensed pharmacist;
- Non-preferred antipsychotic Prescription Drugs prescribed to treat emotional disturbance or Mental Illness will be covered at the same level as preferred Prescription Drugs if the prescribing Health Care Provider indicates that the prescription must be "Dispense As Written" (DAW) and certifies in writing to the Claims Administrator that he/she has determined that the Prescription Drug prescribed will best treat your condition.
- If you are taking a preferred Prescription Drug to treat Mental Illness or emotional disturbance that has effectively treated your condition, the Prescription Drug will be covered at the preferred Prescription Drug level for up to one (1) year when either the Prescription Drug is removed from your specified Preferred Drug List, or if:
    - you have been treated with the Prescription Drug for 90 days prior to a change in your specified Preferred Drug List or a change in your health care Plan;
    - the prescribing Health Care Provider indicates that the prescription must be DAW; and,
    - the prescribing Health Care Provider certifies in writing to the Claims Administrator that the Prescription Drug prescribed will best treat your condition.
- The continuing care benefit will be extended annually if the prescribing Health Care Provider indicates that the prescription must be DAW and certifies in writing to the Claims Administrator that the Prescription Drug prescribed will best treat your condition.
- If the prescribing Health Care Provider believes that you need coverage for a Prescription Drug that is not on your specified Preferred Drug List, there is a process to request an exception. The Health Care Provider must submit a written Exception request to the Claims Administrator. This request must indicate that the preferred Prescription Drug(s) causes an adverse reaction or is contraindicated for the member, or demonstrate that the non-preferred Prescription Drug must be "DAW" to provide maximum benefit to the member.
- The health care Plan will cover off-label Prescription Drugs used for cancer Treatment as specified by law.
- Amino Acid-based Elemental Formula is a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier

for the body to process and digest. An infant or child may be placed on an amino acid-based formula if he/she is unable to digest or tolerate whole proteins found in other formulas, due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, and E028 Splash.

- Coverage for amino acid-based elemental formula is subject to Prior Authorization based on Medical Policy. Please refer to the applicable Prescription Drug members cost sharing under Prescription Drugs in the "Summary of Benefits" section.
- The health care Plan will cover off-label Prescription Drugs used for cancer Treatment as specified by law.
- Benefits are provided for the full range of FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- Benefits are provided for designated ACA preventive drugs with a prescription (such as FDA-approved Tobacco Cessation Drugs and Products, aspirin, folic acid, vitamin D, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or ACA preventive Prescription Drug coverage, please visit www.bluecrossmnonline.com, or contact Member Service at the telephone number listed on the back of your member ID card.
- The Claims Administrator applies medical management in determining which contraceptives are included on your Prescription Drug List, as well as a subset of contraceptive medications where a $0 member liability cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your health care Plan visit www.bluecrossmnonline.com (choose "Live Healthy" tab at the top, then "Preventive Care") or contact Member Service at the telephone number listed on the back of your member ID card. If your prescribing Health Care Provider determines that none of the $0 member cost-sharing options available under your health care Plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmnonline.com (sign in and see "Prescription Drugs" under the "Member Resources" tab).
- Insulin.
- Prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, and lancets.
- Certain Prescription Drugs that may require Prior Authorization from the Claims Administrator.
- If you are prescribed a medication subject to Step Therapy, another eligible medication in the same or different Prescription Drug class must have been prescribed and tried before the medication subject to Step Therapy will be paid under the Prescription Drug benefit. Step Therapy Prescription Drug categories are available on the Claims Administrator’s website at www.bluecrossmnonline.com, or contact Member Service at the telephone number listed on the back of your member ID card.
- Over-the-counter Tobacco Cessation Drugs and Products require a prescription and are subject to your Prescription Drug cost-sharing.
- If you are prescribed a Brand Drug when there is an equivalent Generic Drug, you will also pay the difference in cost between the Brand Drug and the Generic Drug, in addition to the applicable member cost-sharing. When you have reached your Out-of-Pocket Limit, you still pay the difference in cost between the Brand Drug and the Generic Drug, even though you are no longer responsible for the applicable Prescription Drug member cost-sharing. You are also responsible for the payment differential when a Generic Drug is authorized by the Physician and the member purchases a Brand Drug. Your payment is the price difference between the Brand Drug and Generic Drug in addition to the Brand Drug cost-sharing amounts that apply.
- The Retail Pharmacy Vaccine Program allows you the opportunity to receive certain otherwise eligible vaccines at designated participating retail pharmacies subject to your Prescription Drug cost-sharing. This program is in addition to your current vaccine benefit administered through your clinic/Physician's office. A list of eligible vaccines under this program and designated participating pharmacies is available on our website at

www.bluecrossmnonline.com (sign in and see "Prescription Drugs" under the "Member Resources" tab) or contact Customer Service.

- Your Prescription Drug program follows a Prescription Drug List that is available at www.bluecrossmnonline.com, or contact Member Service at the telephone number on the back of your member ID card.
- Self-administered injectable and oral Prescription Drugs for Assisted Fertilization must be obtained through a Specialty Pharmacy Network supplier and are subject to the Lifetime Maximum limit of $10,000 per member for all Assisted Fertilization for all charges and networks combined.
- The Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain Prescription Drugs covered under the health care Plan. Such discounts are the sole property of the Claims Administrator and/or the Plan Administrator and will not be considered in calculating any Coinsurance, Copayment, or benefit maximums.
- There may be a prescription drug travel refill benefit available if you are traveling for an extended period of time within the United States and/or traveling for an extended period of time outside the United States. Please contact Member Services at the telephone number on the back of your member ID card for further information. Restrictions apply.
- These listings are subject to periodic review and modification by the Claims Administrator or a designated committee of Physicians and pharmacists.

Specialty Pharmacy Network Supplier

- Covered Prescription Drugs also include selected Specialty Prescription Drugs within, but not limited to, the following Prescription Drugs classifications only when such Prescription Drugs are covered medications and are dispensed through exclusive Specialty Pharmacy Network supplier. Specialty Prescription Drugs are designated complex injectable and oral drugs generally covered up to a 31-day Supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, Provider coordination, or patient education that cannot be provided by a Retail Pharmacy. Specialty Prescription Drugs are Prescription Drugs including, but not limited to Prescription Drugs used for: Infertility; growth hormone Treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and, hemophilia. A current list of designated Specialty Prescription Drugs and suppliers is available at www.bluecrossmnonline.com, or contact Member Service at the telephone number listed on the back of your member ID card. Specialty Prescription Drugs are not available through 90dayRx.
- Specialty Prescription Drugs may be ordered by a Health Care Provider on your behalf or you may submit the prescription order directly to the Specialty Pharmacy Network supplier. In either situation, the Specialty Pharmacy Network supplier will deliver the prescription to you.

Additional coverage for enteral formula excludes the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system, banked breast milk
- Milk or soy-based infant formula with intact proteins
- Any formula (standard and specialized), when used for the convenience of you or your family members
- Nutritional supplements and electrolyte solution
- Any substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

What Is Not Covered

Except as specifically provided in this health care Plan or as the Claims Administrator is mandated or required to provide based on state or federal law, no benefits will be provided for Services, supplies, Prescription Drugs or charges as noted below.

Exclusions

No benefits will be provided for the following:

1. Personal comfort, hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
2. Operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; c) surgery to correct a functional impairment which results from a covered disease or injury; and, d) Services incidental to or following surgery resulting from injury, sickness or other diseases of the involved body part.
3. Court ordered Services or confinements by a court or law enforcement officer that are not Medically Necessary and Appropriate, except as specified under Minnesota law.
4. Custodial Care, domiciliary care, residential care, protective and supportive care including educational Services, rest cures and convalescent care.
5. Services rendered prior to your effective date of coverage.
6. Services which are Investigative in nature, except for certain routine care for approved clinical trials.
7. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional Services for the fitting and/or Supply thereof, including the Treatment of refractive errors such as radial keratotomy, except as provided herein.
8. Services for eyeglasses or contact lenses for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the Treatment of disease or injury).
9. Services for palliative or cosmetic foot care including flat foot conditions, the Treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or Services are related to the Treatment of diabetes.
10. Services for or related to Treatment leading to or in connection with sex transformation/gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up Treatment, care, and counseling, unless Medically Necessary and Appropriate as determined by the Claims Administrator, based on the most recent published medical standards set forth by nationally recognized medical experts in the transgender health field, prior to receipt of Services.
11. Services for or related to the LINX™ Reflux management System for the Treatment of gastroesophageal reflux disease (GERD).
12. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
13. Charges for the following Services you receive from a Home Health Care Agency, hospice or a Hospital program for Home Health Care and/or Hospice Care: homemaker Services; Maintenance Services; dialysis Treatment; Custodial Care; food or home-delivered meals.
14. Charges for inpatient Admissions which are primarily for diagnostic studies.
15. Services for the Treatment of learning disabilities.
16. Services for or related to marriage/couples counseling.
17. Services for or related to oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.

18. Services for or related to dental implants, except as provided herein.
19. Treatments, Services, or supplies which are not based on the definition of "Medically Necessary and Appropriate" in the "Terms You Should Know" section.
20. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health care Plan and you elect this coverage as primary.
21. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for Service connected Illness or injury, unless you have a legal obligation to pay.
22. Charges for telephone consultations.
23. Charges for the covered patient’s failure to keep a scheduled visit.
24. Charges billed by your Provider for the completion of a Claim form.
25. Charges for any other medical or dental Service or Treatment or Prescription Drug, except as provided herein.
26. For Treatment or Services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such Treatment or Service is eligible, paid or payable under a Plan or policy of motor vehicle insurance, including a certified or qualified Plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for Services that are applied toward any Deductible, Copayment or Coinsurance requirement of such a policy.
27. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
28. Services, including dental splints, to treat Bruxism.
29. Oral surgery procedures, except as provided herein.
30. Charges for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided herein.
31. Services which are not prescribed by or performed by or upon the direction of a professional provider.
32. Services rendered by other than ancillary Providers, Facility Providers or professional Providers.
33. Charges for Services which are submitted by a certified registered nurse and another professional Provider for the same Services performed on the same date for the same member.
34. Services rendered by a Provider who is a member of your Immediate Family.
35. Services performed by a professional Provider enrolled in an education or training program when such Services are related to the education or training program.
36. For Respite Care, except as provided herein.
37. Charges for Skilled Nursing Facility provider Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive Treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for Treatment of Substance Abuse or Mental Illness.
38. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
39. Tobacco cessation drugs and products without a prescription.
40. Charges incurred after the date of termination of your coverage, except as provided herein.
41. Services for outpatient therapy and rehabilitation Services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate.

42. Services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related Services.
43. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate.
44. Services for or related to any Illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you Claim the benefits or compensation.
45. Services that are provided without charge, including Services of the clergy.
46. Expenses incurred for Services, supplies, medical care or Treatment received at a Health Care Provider that represents to a patient that he or she will not owe the required cost sharing amount (including, for example, Deductibles, Copayments, and Coinsurance) described in this Plan.
47. Services for or related to acupuncture, except for the Medically Necessary and Appropriate acupuncture Services for Treatment of chronic pain (defined as a duration of six (6) months; and, for the prevention and Treatment of nausea associated with surgery, chemotherapy, or pregnancy, except as provided herein.
48. Services for Dependents if you have Group Member-only coverage.
49. Services that are not within the scope of licensure or certification of a provider.
50. Services that are prohibited by law or regulation.
51. Charges for furnishing medical records or reports and associated delivery charges.
52. Services for transportation, other than local ambulance Service, to the nearest medical Facility Provider that can provide the necessary Services/is equipped to treat the condition, except as provided herein.
53. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical Facility that can provide the necessary Service/is equipped to treat the condition.
54. Travel Transportation, or living expenses, whether or not recommended by a Physician, except as specified in the "Summary of Benefits."
55. Services for or related for Mental Illness not listed in the most recent editions of the ICD and DSM.
56. Charges for evaluations that are not performed for the purpose of diagnosing or treating mental health or Substance Abuse conditions such as: custody evaluations; parenting assessments; education classes for DUI or DWI offences; competency evaluations; adoption home status; parental competency; and domestic violence programs.
57. Services for or related to room and board for foster care, group homes, shelter care and lodging programs, Halfway House Services and Skills Training.
58. Services for or related to therapeutic support of foster care.
59. Services for or related to Substance Abuse or Addictions that are not listed in the most recent editions of the ICD and DSM.
60. Services for or related to therapeutic massage.
61. Charges for personal comfort items such as telephone, television.
62. Charges for communication Services provided on an outpatient basis or in the home.
63. Services for or related to elective cesarean (C)-section for the purpose of convenience.
64. Services for or related to Experimental Infertility Treatment procedures, surrogacy Services, or cryopreservation of eggs or sperm.
65. Charges for donor ova or sperm.
66. 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.
67. Charges for or related to reversal of sterilization.

68. Scalp/cranial hair prostheses (wig) for any diagnosis other than alopecia areata.
69. Charges for blood pressure monitoring devices.
70. Services provided during an E-Visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and, Services that would similarly not be charged for in an onsite medical office visit.
71. Provider initiated e-mail communications.
72. Services provided during a Telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; and, additional communication on the same day as an onsite medical office visit; and Services that would similarly not be charged for in an onsite medical office visit.
73. Facsimile transmission communications between members and providers.
74. Charges for giving injections that can be self-administered, except as provided in Medical Policy.
75. Services related to vocational rehabilitation.
76. Services and fees for or related to health clubs and spas.
77. Maintenance Services.
78. Services for or related to recreational and educational therapy.
79. Services and supplies for weight loss programs.
80. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
81. Services for or related to gene therapy (considered experimental) as a Treatment for inherited or acquired disorders.
82. Charges for growth hormone replacement therapy, except for Services that meet medical necessity criteria.
83. Charges for autopsies.
84. Over the counter drugs, e.g. vitamins or dietary supplements, except as provided herein.
85. Services, supplies, drugs and Aftercare for or related to artificial or nonhuman organ implants.
86. Services for or related to fetal tissue transplantation.
87. Charges for routine dental care, except as provided herein.
88. Charges for Foot Orthoses, except as provided herein.
89. Services for or related to Skilled Nursing Care - Extended Hours, also referred to as private-duty nursing care, except as required by Minnesota Law.
90. 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 provided herein.

In addition, under your Prescription Drug benefits, except as specifically provided in this health care Plan or as the Claims Administrator is mandated or required to provide based on state or federal law, no benefits will be provided for:

91. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
92. Charges for administration of self-administered Prescription Drugs and/or injectable insulin, whether by a Physician or other person, except as provided in Medical Policy.
93. Any charges by any pharmacy Provider or pharmacist, except as provided herein.
94. Charges for Investigative or non-Food and Drug Administration (FDA) approved drugs, except as specified by law.
95. Any amounts above the Deductible, Coinsurance, Copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.

96. Charges for any prescription for more than the retail days Supply or 90dayRx days Supply as outlined in the "Summary of Benefits" section, except as provided herein.
97. Charges for any drug or medication which does not meet the definition of Maintenance Prescription Drug, except those set forth in the predefined preventive schedule. Please refer to the "Covered Services - Prescription Drug Program" section for more information.
98. Charges for Prescription Drugs for the Treatment of sexual dysfunction including, but not limited to erectile dysfunction.
99. Charges for over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the "Covered Services - Prescription Drug Program" section for more information.
100. Charges for food supplements.
101. Charges for any drugs prescribed for cosmetic purposes only.
102. Charges for any drugs which are Investigative.
103. Charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
104. Charges for cosmetic alteration medications/drugs.
105. Charges for weight loss medications/drugs.
106. Charges for Specialty drugs not purchased through a Specialty Pharmacy Network supplier.
107. Charges for drugs removed from the Preferred Drug List due to safety reasons may not be covered.

How Your Program Works

Your health care Plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care Services: **Network** or **Out-of-Network.**

Network Care

Network care is care you receive from providers in the health care Plan's network.

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

Out-of-Network Care

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

Even when you go outside the network, you will still be covered for eligible Services. However, your benefits generally will be paid at the lower, Out-of-Network level. Additionally, Precertification may be required from the Claims Administrator before Services are received. For specific details, see your "Summary of Benefits" section.

Please note that you may incur significantly higher financial liability when you use Nonparticipating Providers compared to the cost of receiving care from Network Providers. If you receive Services from a Nonparticipating Provider, you will be responsible for any Deductibles or Coinsurance plus the DIFFERENCE between what the Claims Administrator would reimburse for the Nonparticipating Provider and the actual charges the Nonparticipating Provider bills. This difference does not apply to your Out-of-Pocket Limit. This is in addition to any applicable Deductible, Copay or Coinsurance. Benefit payments are calculated on the Claims Administrator’s Allowed Amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the Facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional Services.

Out-of-Area Care

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

Services received from providers across the country who are part of the local Blue Cross and Blue Shield Traditional network will be covered at the higher level of benefits. If you receive Covered Services from a provider who is not part of the local Blue Cross and Blue Shield Traditional network, these Services will be covered at the lower, Out-of-Network level of benefits.

If you are traveling and an urgent injury or Illness occurs, you should seek Treatment from the nearest Hospital, emergency room or clinic:

- If the Illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield Traditional network. If the Treatment results in an Admission, the local Blue Cross and Blue Shield Traditional Network Provider must obtain Precertification from the Claims Administrator. However, it is important that you confirm the Claims Administrator’s determination of Medical Necessity and Appropriateness. If the Admission is not considered to be Medically Necessary and Appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.
- If the Illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield Traditional network in order to be covered at the higher benefit level. If you receive care from an Out-of-Network Provider, benefits for eligible Services will be provided at the lower, Out-of-Network level of benefits.

General Provider Payment Methods

Participating Providers

- Several industry-standard methods are used to pay Health Care Providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.
- Depending upon your health care Plan, a Participating Provider may be a Network Provider or may be an Out-of-Network Provider. Payment will be based upon which network the Participating Provider is in for your health care Plan. See "How Your Program Works" for additional detail on Covered Services received in the network and Out-of-Network.

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - **Fee-for-Service -** Providers are paid for each Service or bundle of Services. Payment is based on the amount of the provider's billed charges.
  - **Discounted Fee-for-Service -** Providers are paid a portion of their billed charges for each Service or bundle of Services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare Services.
  - **Discounted Fee-for-Service, Withhold and Bonus Payments -** Providers are paid a portion of their billed charges for each Service or bundle of Services, and a portion (generally 5-20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive Services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

  Payment for high cost cases and selected preventive and other Services may be excluded from the discounted fee-for-Service and withhold payment. When payment for these Services is excluded, the provider is paid on a discounted fee-for-Service basis, but no portion of the provider's payment is withheld.

- Institutional (i.e., Hospital and other Facility provider) Participating Provider Payments
  - Inpatient Care
    - **Payments for each Case (case rate) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of Admission, regardless of the number of days that the member is Hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare Services.
    - **Payments for each Day (per diem) -** Providers are paid a fixed amount for each day the member spends in the Hospital or Facility provider.
    - **Percentage of Billed Charges** - Providers are paid a percentage of the Hospital's or Facility provider's billed charges for inpatient or outpatient Services, including home Services.
  - Outpatient Care
    - **Payments for each Category of Services** - Providers are paid a fixed or bundled amount for each category of outpatient Services a member receives during one (1) or more related visits.
    - **Payments for each Visit** - Providers are paid a fixed or bundled amount for all related Services a member receives in an outpatient or home setting during one (1) visit.

- **Payments for each Patient** - Providers are paid a fixed amount per member per Calendar Year for certain categories of outpatient Services.

Special Incentive Payments

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a Claim based on the quality of the provider's care to their members and further based on Claims savings that the provider may generate in the course of rendering cost effective care to its member. Certain providers also may be paid in advance of a Claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: Services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage Claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a Claims payment for Services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered Claims payment.

Pharmacy Payment

Four (4) kinds of pricing are compared and the lowest amount of the four (4) is paid:

- the average wholesale price of the Prescription Drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost the Claims Administrator determines by comparing market prices (for Generic Drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

Nonparticipating Providers are not Network Providers. Payment for Covered Services provided by a Nonparticipating Provider will be at the Out-of-Network level. See "How Your Program Works" for additional detail on Covered Services received in the network and Out-of-Network.

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield Plan. For Services received from a Nonparticipating Provider (other than those described under "Special Circumstances" below), the Allowed Amount will be based upon one of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar Service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield Plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by Blue Cross. The Allowed Amount for a Nonparticipating Provider is usually less than the Allowed Amount for a Participating Provider for the same Service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the health care Plan and you are responsible for paying the Nonparticipating Provider. The only exception to this is stated in "Claims Procedures," "Claims Payment." The amount you pay does not apply toward any Out-of-Pocket Limit contained in the Plan.

In determining the Allowed Amount for Nonparticipating Providers, the Claims Administrator makes no representations that the Allowed Amount is a usual, customary or reasonable charge from a provider. See "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for Services provided by Nonparticipating Providers.

- Example

  The following table illustrates the different out-of-pocket costs you may incur using nonparticipating versus Participating Providers. The example presumes that your Deductible has been satisfied and that the health care Plan covers 80% for Participating Providers and 60% for Nonparticipating Providers. It also presumes that the

Allowed Amount for a Nonparticipating Provider will be less than for a Participating Provider. The difference in the Allowed Amount between a Participating and Nonparticipating Provider could be more or less than the 20% difference in the example below.

	Participating Provider	**Nonparticipating Provider**
Provider Charge:	$150	$150
Allowed Amount:	$100	$80
Claims Administrator Pays:	80% ($80)	60% ($48)
Coinsurance You Owe:	20% ($20)	40% ($32)
Difference Up to Billed Charge You Owe:	None	$70 ($150 minus $80)
You Pay:	$20	$102

Special Circumstances

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

The above is a general summary of our provider payment methodologies only. Further, while efforts are made to keep this form as up-to-date as possible, provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Please note that some of these payment methodologies may not apply to your particular Plan.

Women's Health and Cancer Rights Act

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

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

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

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

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

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

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

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

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

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

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health Services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health Services are ordinarily or exclusively available. Eligible, Covered Services must be Medically Necessary and Appropriate, and remain subject to any requirements outlined in the Claims Administrator's medical policy and/or federal law.

Inter-Plan Programs

Out-of-Area Services

Overview

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care

Services outside the geographic area the Claims Administrator serves, the Claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the claims Administrator's Services area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The Claims Administrator explains how we pay both kinds of providers.

Inter-Plan Programs Eligibility - Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care benefits except when paid as medical Claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Plan Administrator to provide the specific Service or Services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you receive covered health care Services outside the Claims Administrator's Service Area and the Claim is processed through the BlueCard Program, the amount you pay for covered health care Services is calculated based on the lower of:

- the billed charges for your Covered Services; or,
- the negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to employer on your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

When covered health care Services are provided outside of the Claims Administrator's Service Area by Nonparticipating Providers, the amount you pay for such Services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Nonparticipating Provider bills and

the payment the Claims Administrator will make for the covered health care Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency Services.

Blue Cross Blue Shield Global® Core

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

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

Inpatient Services

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient Services, except for your Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin Claims processing. However, if you paid in full at the time of Service, you must submit a Claim to receive reimbursement for covered health care Services. You must contact the Claims Administrator to obtain Precertification for non-emergency inpatient Services.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for covered health care Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global® Core Claim form and send the Claim form with the provider's itemized bill(s) to the Service center (the address is on the form) to initiate Claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The Claim form is available from the Claims Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim, submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Out-of-Country Benefits

Eligible Services coordinated through the Blue Cross Blue Shield Global® Core (see "Inter-Plan Programs," "Blue Cross Blue Shield Global Core®") program will process at the Network level of coverage.

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

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

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

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of Physicians; a wide range of Specialists; a wide variety of mental health and Substance Abuse providers; community and specialty Hospitals; and laboratories in the health care Plan Service Area.

To determine if your Physician is in the network, call the Member Service toll-free telephone number listed on the back of your member ID card.

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

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

Remember:

If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or Facility provider is in the network. Your provider directory lists Network Providers in our Service area and may change from time to time, including as providers or the Claims Administrator initiate or terminate network contracts. Prior to receiving Services, it is recommended that you verify your Provider's network status with the Claims Administrator, including whether the Provider is a Network Provider for your particular Plan. Not every provider is a Network Provider for every Plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Sign in" then "Find a Doctor") or call the Member Service toll-free telephone number listed on the back of your member ID card. For benefit information, refer to the "Summary of Benefits."

How to Get Your Physicians' Professional Qualifications

To view Board Certification information, Hospital affiliation or other professional qualifications of your provider, visit your member website at www.bluecrossmnonline.com, or call Member Service at the telephone number listed on the back of your member ID card.

Network Pharmacies

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

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

- **90dayRx:** 90dayRx Pharmacy includes 90dayRx participating Retail, and Mail Order Pharmacy. These options offer savings and convenience for prescriptions you may take on an ongoing, long-term basis.
  - To utilize a 90dayRx participating Retail Pharmacy, verify that your pharmacy participates in the Network and present your prescription for a 90-day fill of the eligible prescription medication.
  - To start using mail order pharmacy:
    - Ask your doctor to write a prescription for up to a 90-day Supply, plus refills for up to one year, if appropriate.
      - Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Service or from your member website. After logging in, click on "Fill Rx" at the top of the home page. Then click on "Health & Benefits Information" and select the "Print Forms" link.

    Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed. Your mail order will include directions for ordering refills.

- **Specialty Pharmacy Network Supplier:** The Specialty Pharmacy Network supplier has an agreement, with the Claims Administrator pertaining to the payment and exclusive dispensing of selected Specialty Prescription Drugs provided to you. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected Specialty Prescription Drug categories.

Health Care Management

Medical Management

The Claims Administrator reviews Services to verify that they are Medically Necessary and Appropriate and that the Treatment provided is the proper level of care. All applicable terms and conditions of your Plan including exclusions, Deductibles, Copayments, and Coinsurance provisions continue to apply with an approved Prior Authorization, preadmission notification, preadmission certification, and/or emergency Admission notification.

Prior Authorization, preadmission notification, preadmission certification, and/or emergency Admission notification are required.

Prior Authorization

Prior Authorization is a process that involves a benefits review and determination of medical necessity before a Service is rendered. The Claims Administrator's Prior Authorization list describes the Services for which Prior Authorization is required. The Prior Authorization list is subject to change due to changes in the Claims Administrator's medical policy. The Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Claims Administrator's website at www.bluecrossmnonline.com or call Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

For **inpatient Hospital/Facility Services**, all Network Providers and Out-of-Network Participating Providers are required to obtain Prior Authorization for you. You are required to obtain Prior Authorization when you use Nonparticipating Providers in Minnesota and any Provider outside of Minnesota. Some of these Providers may obtain Prior Authorization for you. Verify with your Providers if this is a Service they will perform for you or not.

For **outpatient Hospital/Facility Services or professional Services,** Minnesota Network Providers and Minnesota Out-of-Network Participating Providers are required to obtain Prior Authorization for you. You are required to obtain Prior Authorization when you use Nonparticipating Providers in Minnesota and any provider outside of Minnesota. Some of these providers may obtain Prior Authorization for you. Verify with your providers if this is a Service they will perform for you or not.

Minnesota Network Providers who do not obtain Prior Authorization for you are responsible for the charges if the Services are found to be not Medically Necessary and Appropriate. For Claims from a Nonparticipating Provider in Minnesota, or any Provider outside Minnesota, if Prior Authorization is not obtained and if it is found, at the point the Claim is processed, that Services were not Medically Necessary and Appropriate, you are liable for all of the charges.

The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/Services to determine if the Services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the Prior Authorization request contains all the information needed to review the Service.

Expedited review determination

Blue Cross will use an expedited review determination when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize Services, you may submit an expedited appeal. See the Appeal Process section for more information about submitting an expedited appeal.

The Claims Administrator prefers that all requests for Prior Authorization be submitted to them in writing to ensure accuracy. Please call Member Service at the telephone number listed on the back of your member ID card for the appropriate mailing address for Prior Authorization requests.

Preadmission Notification

Preadmission notification is a process whereby the provider, or you, inform the Claims Administrator that you will be admitted for inpatient Hospitalization Services. This notice is required in advance of being admitted for Inpatient Care for any type of nonemergency Admission and for Partial Hospitalization.

All Network Providers and Out-of-Network Participating Providers are required to provide preadmission notification for you. If those Providers do not provide preadmission notification for you, then those Providers are responsible for the charges if the Admission is found to be not Medically Necessary and Appropriate.

If you are going to receive nonemergency Inpatient Care from Nonparticipating Providers in Minnesota, or any Provider outside Minnesota, you are required to provide preadmission notification to the Claims Administrator. Some of these providers may provide preadmission notification for you. Verify with your provider if this is a Service they will perform for you or not. **You may also be required to obtain Prior Authorization for the Services or procedures while you are inpatient; for instance if you are having elective surgery while inpatient at a Nonparticipating Provider. Please refer to "Prior Authorization" in this section to determine if you, or your Provider, are responsible for obtaining any required Prior Authorization(s). For Claims from a Nonparticipating Provider in Minnesota or any Provider outside Minnesota, if preadmission notification is not obtained and it is found, at the point the Claim is processed, that Services were not Medically Necessary and Appropriate, you are liable for all the charges.**

Preadmission notification is required for the following Admissions/facilities:

1. Hospital acute care Admissions (medical and behavioral); and,
2. Residential behavioral health Treatment facilities.

To provide preadmission notification, call Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or Services. Preadmission certification includes concurrent/length-of-stay review for inpatient Admissions. This notice is required in advance of being admitted for Inpatient Care for any type of nonemergency Admission and for Partial Hospitalization.

All Network Providers and Out-of-Network Participating Providers are required to provide preadmission certification for you. If those Providers do not provide preadmission certification for you, then those Providers are responsible for the charges if the Admission is found to be not Medically Necessary and Appropriate.

If you are going to receive nonemergency Inpatient Care from Nonparticipating Providers in Minnesota, or any Provider outside Minnesota, you are required to provide preadmission certification to the Claims Administrator. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a Service they will perform for you or not. **You may also be required to obtain Prior Authorization for the Services or procedures while you are inpatient; for instance if you are having elective surgery while inpatient at a Nonparticipating Provider. Please refer to "Prior Authorization" in this section to determine if you, or your Provider, are responsible for obtaining any required Prior Authorization(s). For Claims from a Nonparticipating Provider in Minnesota or any Provider outside Minnesota, if preadmission notification is not obtained and it is found, at the point the Claim is processed, that Services were not Medically Necessary and Appropriate, you are liable for all the charges.**

Preadmission certification is required for the following Admissions/facilities:

1. Acute rehabilitation (ACR) Admissions;
2. Long-term acute care (LTAC) Admissions; and,
3. Skilled nursing facilities.

To provide preadmission certification, call Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

Emergency Admission Notification

In order to avoid liability for charges that are not considered Medically Necessary and Appropriate, you are required to provide emergency Admission notification to the Claims Administrator within 48 hours of the Admission, or as soon as reasonably possible following the Admission. You can contact Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

Minnesota Network Providers and Out-of-Network Participating Providers are required to provide emergency Admission notification for you and are responsible for charges for any Services found to be not Medically Necessary and Appropriate.

If you receive emergency care from Nonparticipating Providers in Minnesota, or any Provider outside Minnesota, you are required to provide emergency Admission notification to the Claims Administrator within 48 hours of the Admission or as soon as reasonably possible following the Admission. Some of these providers may provide emergency Admission notification for you. Verify with your provider if this is a Service they will perform for you. For Claims from a Nonparticipating Provider in Minnesota, or any Provider outside Minnesota **if this notification is not obtained and it is found, at the point the Claim is processed, that Services were not Medically Necessary and Appropriate, you are liable for all of the charges.**

To provide emergency Admission notification, call Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

Continuity of Care

Continuity of Care for New Members

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

Continuation for up to 120 days if you:

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

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

Transition to Network Providers

The Claims Administrator will assist you in making the transition from an Out-of-Network to a Network Provider if you request them to do so. Please contact Member Service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Claims Administrator's Prior Authorization requirements and, 2) provide the Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to Services that are not covered under the health care Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one Plan to another.

Provider Termination for Cause

If it is known that the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Network Provider must occur on or prior to the date of such termination for you to continue to receive Network benefits.

Continuity of Care for Current Members

If you are a current member or Dependent, this section applies to you. If the relationship between your Network clinic or Physician and the Claims Administrator ends, rendering your clinic or provider Out-of-Network, and the termination was by the Claims Administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an Participating Provider as required under the terms of your coverage under the health care Plan. The Claims Administrator will authorize this continuation of care for a terminal Illness in the final stages or for the rest of your life if a Physician, advanced practice nurse, or Physician assistant certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of Treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

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

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

Transition to Network Providers

The Claims Administrator will assist you in making the transition from an Out-of-Network to a Network Provider if you request them to do so. Please contact Member Service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Claims Administrator's Prior Authorization requirements and 2) provide the Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to Services that are not covered under the health care Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one Plan to another.

Provider Termination for Cause

If it is known that the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to a Network Provider must occur on or prior to the date of such termination for you to continue to receive Network benefits.

General Information

Plan Administration

Plan Administrator

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

Powers and Duties of the Plan Administrator

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

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

Actions of the Plan Administrator

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

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

Nondiscrimination

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

Time Periods

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

Termination or Changes to the Plan

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

The Employer reserves the power at any time and from time to time (and retroactively) to terminate, modify or amend, in whole or in part, any or all provisions of the health care Plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the health care Plan. Any amendment to this health care Plan may be effected by a written resolution adopted by the Plan Administrator. The Plan Administrator will communicate any adopted changes to the Employees.

Funding

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

Controlling Law

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

Fraudulent Practices

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

Payments Made in Error

Payments made in error or overpayments may be recovered by the Claims Administrator as provided by law. Payment made for a specific Service or erroneous payment shall not make the Claims Administrator or the Plan Administrator liable for further payment for the same Service.

Medical Policy Committee and Medical Policies

The Claims Administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the Claims Administrator's Medical Policy Committee, which is made up of independent community Physicians who represent a variety of medical specialties. The remaining policies are approved by other external specialists. For all policies, the Claims Administrator's goal is to find the right balance between making improved Treatments available and guarding against unsafe or unproven approaches. From time-to-time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the Claims Administrator's policies in effect at the time Treatment is rendered or, if applicable, Prior Authorization may also be required. Internally developed medical policies can be found at the member website. All medical policies are available upon request.

Who is Eligible

NOTE: If both you and your spouse are employees of the Employer, you may be covered as either an employee or as a Dependent, but not as both. Your eligible Dependent children may be covered under either parent's coverage, but not both.

Eligible Employees

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

Spouse

Spouse, meaning:

1. Spouse to whom you are legally married.
2. A domestic partner shall be considered for eligibility as long as a domestic partnership (a voluntary relationship between two domestic partners) exists with you. In addition, the children of the domestic partner shall be considered for eligibility as if they were your children as long as the domestic partnership exists.

   "Domestic Partner" means a member of a domestic partnership consisting of two partners, each of whom has registered with a domestic partner registry in effect in the municipality/governmental entity within which the domestic partner currently resides, or who meets the definition of a domestic partner as defined by the state or local government where the individual currently resides or meets all of the following:

   - is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time
   - is not related to the other partner by adoption or blood
   - is the sole domestic partner of the other partner and has been a member of this domestic partnership for the last six months
   - agrees to be jointly responsible for the basic living expenses and welfare of the other partner
   - meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

Dependent Children

Children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:

- Newborn children
- Stepchildren
- Grandchildren who live with you or your spouse continuously from birth and are financially dependent upon you or your spouse
- Children legally placed for adoption
- Legally adopted children and children for whom the employee or the employee's spouse is the child’s legal guardian
- Foster children
- Children awarded coverage pursuant to an order of court

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

Disabled Dependent Children

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

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

Adding New Employees

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

Adding New Employees

1. If the Plan Administrator receives your application within 30 days after you become eligible, coverage for you and your eligible Dependents starts the First Day Employed.

Adding New Dependents

Adding a Spouse and/or Stepchildren

1. If the Plan Administrator receives the application within 30 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

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

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

Adding Disabled Dependents

To be eligible for Dependent coverage, proof that Dependents meet the above criteria may be required.

1. If the Plan Administrator receives the application within 30 days of the date of eligibility, coverage for your disabled Dependent starts on the date of eligibility.

Special Enrollment Periods

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

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or Rescission): • Loss of eligibility for employer-sponsored coverage • Plan no longer offers benefits • Termination of all employer contributions • Termination of employment or reduction in hours • Legal separation or divorce • Loss of Dependent child status • Death of employee • Move outside HMO or ACO Service Area • Exceeding the Plan's Lifetime Maximum • Employer bankruptcy • COBRA exhaustion • Employee becomes entitled to Medicare
Minimum Essential Coverage includes coverage under specified government sponsored Plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a Dependent due to marriage.

Special Enrollment Triggering Event
Gaining a Dependent due to birth, adoption, placement for adoption, or placement for foster care.
An individual that loses or gains eligibility for Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the Claims Administrator with 60 days.
Child support order or other Court order to provide coverage.

Changes in Membership Status

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

Leave of Absence or Layoff

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

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

1. For you and your Dependents, the date on which the health care Plan terminates.
2. For you and your Dependents, the Last Day of Month:
    a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the Claims Administrator receives full payment when due. If the Claims Administrator terminates coverage for all employees in the health care Plan for nonpayment of the charges, the Claims Administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
    b. you are no longer eligible.
    c. you enter military Service for duty lasting more than 31 days.
    d. you request that coverage be terminated.
    e. you retire.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the Last Day of Month the employee and spouse divorce or legally separate or the domestic partner no longer meets the domestic partner requirements.
4. For a Dependent child, the date the Dependent child is no longer eligible for coverage. This is the Last Day of Month:
    a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
    b. a covered Dependent is no longer eligible because the employee and the domestic partner terminate their domestic partnership.
    c. the Dependent child reaches the Dependent-child age limit.
    d. the disabled Dependent is no longer eligible.

Extension of Benefits

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

Continuation of Coverage

You or your covered Dependents may continue this coverage if coverage ends due to one of the qualifying events listed below. You and your eligible Dependents must be covered on the day before the qualifying event in order to continue coverage.

Qualifying Events

If you are the ***Employee*** and are covered, you have the right to elect continuation coverage if you lose coverage because of any one (1) of the following qualifying events:

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment).
- Total disability - Total disability means the ***Employee's*** inability to engage in or perform the duties of the ***Employee's*** regular occupation or employment within the first two (2) years of disability. After the first two (2) years, it means the ***Employee's*** inability to perform any occupation for which the ***Employee*** is educated or trained.

If you are the ***spouse/ex-spouse*** of a covered ***Employee***, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the ***Employee***.
- A termination of the ***Employee's*** employment (as described above) or reduction in the ***Employee's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***Employee***. (This includes if the ***Employee*** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the Plan Administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The ***Employee*** becomes enrolled in Medicare.
- The ***Employee*** becomes Totally Disabled (as defined above).

A ***Dependent child*** of a covered ***Employee*** has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the ***Employee***.
- The termination of the ***Employee's*** employment (as described above) or reduction in the ***Employee's*** hours of employment with the employer.
- Parents' divorce or legal separation.
- The ***Employee*** becomes enrolled in Medicare.
- The Dependent ceases to be a "Dependent child" under this group contract.
- The Total Disability of the ***Employee*** (as defined above).

Your Notice Obligations

You and your Dependents must notify the Employer of any of the following events within 60 days of the occurrence of the event:

- divorce or legal separation; or,
- a Dependent child no longer meets the group contract's eligibility requirements.

If you or your Dependents do not provide this required notice, any Dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your Dependents do not provide this required notice, you or your

Dependent must reimburse any Claims mistakenly paid for expenses incurred after the date coverage actually terminates.

Note: Disability Extensions also require specific notice. See below for these notification requirements.

When you notify the Employer of a divorce, legal separation, or a loss of Dependent status, the Employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Employer of a qualifying event or disability determination and the Employer determines that there is no extension available, the Employer will provide an explanation as to why you or your Dependents are not entitled to elect continuation coverage.

Employer's and Plan Administrator's Notice Obligations

The Employer has 30 days to notify the Plan Administrator of events they know have occurred, such as termination of employment or death of the ***Employee***. This notice to the Plan Administrator does not occur when the Plan Administrator is the ***Employer.*** After Plan administrators are notified of the qualifying event, they have 14 days to send the qualifying event notice. Qualified beneficiaries have 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage ends due to the qualifying event or the date of the qualifying event notice, whichever is later.

The Employer will also notify you and your Dependents of the right to elect continuation coverage after receiving notice that one of the following events occurred and resulted in a loss of coverage: the ***Employee's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***Employee's*** becoming enrolled in Medicare.

Election Procedures

You and your Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after you or your family member receive notice of the right to elect continuation coverage. *If you or your Dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage*.

You or your Dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor Dependent child who is eligible to continue coverage. In addition, a Dependent may elect continuation coverage even if the covered ***Employee*** does not elect continuation coverage.

You and your Dependents may elect continuation coverage even if covered under another employer-sponsored group health Plan or enrolled in Medicare.

How to Elect

Contact the Employer to determine how to elect continuation coverage.

Type of Coverage

Generally, continuation coverage is the same coverage that you or your Dependent had on the day before the qualifying event. Anyone who is not covered under the group contract on the day before the qualifying event is generally not entitled to continuation coverage. Exceptions include: 1) when coverage was eliminated in anticipation of a divorce or legal separation, the later divorce or legal separation is considered a qualifying event even though the ex-spouse/spouse lost coverage earlier; and, 2) a child born to or placed for adoption with the covered ***Employee*** during the period of continuation of coverage may be added to the coverage for the duration of the qualified beneficiary's maximum continuation period.

Qualified beneficiaries are provided the same rights and benefits as similarly-situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly-situated active employees or their Dependents, then continuation coverage will be modified in the same way. Examples include: 1) If the group offers an open enrollment period that allows active employees to switch between Plans without being considered late entrants, all qualified beneficiaries on continuation are allowed to switch Plans as well; and, 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation are afforded this same right.

Maximum Coverage Periods

Continuation coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of Continuation Coverage Before the End of the Maximum Coverage Period." In other instances, the maximum coverage period can be extended as described under the heading "Extension of Maximum Coverage Periods."

18 Months. If you or your Dependent loses coverage due to the ***Employee's*** termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period is 18 months from the first of the month following termination or reduction in hours.

36 Months. If a Dependent loses coverage because the ***Employee*** became enrolled in Medicare or because of a loss of Dependent status under the group contract, then the maximum coverage period (for spouse and Dependent child) is three (3) years from the date of the qualifying event.

Indefinite Under Minnesota Law. If you or your Dependents lose coverage because of the ***Employee's*** Total Disability (as defined above), then the maximum coverage period is indefinite. If a Dependent loses group health coverage because of the ***Employee's*** death, divorce, or legal separation, then the maximum coverage period (for ex-spouse/spouse and Dependent child) is indefinite.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a Dependent's disability, the premiums for continuation can be up to 150% of the group rate for months 19-29 if the disabled Dependent is covered. If the qualifying event for continuation is the ***Employee's*** Total Disability, the administration fee is not permitted. All premiums are paid directly to the Employer.

Extension of Maximum Coverage Periods

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

- ***Disability Extension***: This extension is applicable when the qualifying event is the ***Employee's*** termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If your Dependent who is a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

  Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***Employee's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and, 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the Plan's procedures for providing such notice to the administrator.

  Notice Obligation: The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the ***Employee's*** termination of employment or reduction of hours).

  Notice Obligation: If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of: 1) the first day of the month following 30 days after a final determination by the SSA that the formerly disabled qualified beneficiary is no longer disabled; or, 2) the end of the coverage period that applies without regard to the disability extension.

- ***Multiple Qualifying Events***: This extension is applicable when the initial qualifying event is the ***Employee's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month or an indefinite maximum coverage period. The extension applies to the ***Employee's*** Dependents who are qualified beneficiaries.

  When a second qualifying event occurs that gives rise to a 36-month maximum coverage period for the Dependent, the maximum coverage period (for the Dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second

qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension will occur.

When a second qualifying event occurs that gives rise to an indefinite maximum coverage period for the Dependent, then the maximum coverage period (for the Dependent) becomes indefinite. For an indefinite maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given, no extension of continuation coverage will occur.

- ***Pre-Termination or Pre-Reduction Medicare Enrollment:*** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the ***Employee's*** Medicare enrollment. The extension applies to the ***Employee's*** Dependents who are qualified beneficiaries.
  If the qualifying event occurs within 18 months after the ***Employee*** becomes enrolled in Medicare, regardless of whether the ***Employee's*** Medicare enrollment is a qualifying event (causing a loss of coverage under the group contract), the maximum period of continuation for the ***Employee's*** Dependents who are qualified beneficiaries is three (3) years from the date the ***Employee*** became enrolled in Medicare. Example: ***Employee*** becomes enrolled in Medicare on January 1. ***Employee's*** termination of employment is May 15. The ***Employee*** is entitled to 18 months of continuation from the date coverage is lost. The ***Employee's*** Dependents are entitled to 36 months of continuation from the date the ***Employee*** is enrolled in Medicare.

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

- ***Employer's Bankruptcy****:* The bankruptcy rule, technically, is an initial qualifying event rather than an extending rule. However, because it would result in a much longer maximum coverage period than 18 or 36 months, it is included here. If the Employer files Chapter 11 bankruptcy, it may trigger COBRA coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and Dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the group contract, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the ***Employee*** and Dependents will automatically terminate when any one of the following events occur:

- The Employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit Claims) that permits termination of coverage for cause with respect to any covered ***Employees*** or their Dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

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

Children Born to or Placed for Adoption With the Covered Employee During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***Employee*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***Employee*** is a qualified beneficiary and has elected continuation coverage for himself/herself. The child's continuation coverage begins on the date of birth, adoption or placement for adoption as outlined in the "Eligibility" section, and it lasts for as long as continuation coverage lasts for other family members of the ***Employee***.

Open Enrollment Rights and Special Enrollment Rights

Qualified beneficiaries who have elected continuation will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for Dependents at open enrollment. Special enrollment rights apply to those who have elected continuation. Except for certain children described above, Dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified

beneficiaries - their coverage will end at the same time that coverage ends for the person who elected continuation and later added them as Dependents.

Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your Dependents address changes, you *must* notify the Plan Administrator in writing so the Plan Administrator may mail you or your Dependent important continuation notices and other information. Also, if your marital status changes or if a Dependent ceases to be a Dependent eligible for coverage under the terms of the group contract, you or your Dependent *must* notify the Plan Administrator in writing. In addition, you must notify the Plan Administrator if a disabled ***Employee*** or family member is no longer disabled.

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 runs concurrently with 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.

Questions

If you have general questions about continuation of coverage, please call the telephone number on the back of your identification card for assistance.

Overview

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

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and Dependents	Earlier of: 1. 18 months, or 2. Enrollment Date in other group coverage.
Divorce or legal separation	Ex-spouse/spouse and any Dependent children that lose coverage	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end.
Death of Employee	Surviving spouse and Dependent children	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end if the Employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.

Qualifying Event	Who May Continue	Maximum Continuation Period
Dependents lose eligibility due to the Employee's enrollment in Medicare	All Dependents	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the Employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation.
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Total disability of Employee	Employee and Dependents	Earlier of: 1. Date Total Disability ends, or 2. Date coverage would otherwise end.
Extensions to 18-month maximum continuation period: Total disability of Dependent(s)	Disabled Dependent and all other covered family members	Earliest of: 1. 29 months after the Employee leaves employment, or 2. Date Total Disability ends, or 3. Date coverage would otherwise end.

Coordination 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. Your benefits under This Plan may be reduced if another Plan pays first.

Definitions

These definitions apply only to this section.

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

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

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

   c. individual coverage.

   d. The medical payment ("medpay") or personal injury protection benefit available to you under and 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.

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

   Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate Plan.

2. "This Plan" means the part of the group contract 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 as to some Plans, and may be a secondary Plan as to other Plans.

Notes:

a. If you are covered under This Plan and Medicare: This Plan will comply with the 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 Benefits 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 item of expense for health care, covered at least in part by one (1) or more Plans covering the person making the Claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or This Plan. "Allowable expense" does not include outpatient Prescription Drugs, except those eligible under Medicare (see number 3 above).

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

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

Order of Benefits Rules

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. Non-Dependent/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: 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, c. 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 a shorter time.

Effect on Benefits of This Health Care Plan

When this section applies:

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

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

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

Right of Recovery

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

1. the persons This Plan paid for whom This Plan has paid;
2. insurance companies; and
3. other organizations.

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

Reimbursement and Subrogation

We pay if the health care Plan pays benefits for medical expenses you incur as a result of any act of any person, and you later obtain full compensation, you are obligated to reimburse the health care Plan for the benefits paid. If you or your Dependents receive benefits under this health care Plan arising out of Illness or injury for which a responsible party is or may be liable, the health care Plan is also entitled to subrogate against any person, corporation and/or other legal entity, or any insurance coverage, including both first- and third-party automobile coverages to the full extent the health care Plan provided any benefits. The health care Plan's right to reimbursement and subrogation is subject to you obtaining full recovery, as explained in Minnesota statutes 62A.095 and 62A.096. Unless the health care Plan is separately represented by its own attorney, the health care Plan's right to reimbursement and subrogation is subject to reduction for first, the health care Plan's pro rata share of costs, disbursements, and then reduced by reasonable attorney fees incurred in obtaining the recovery.

If the health care Plan is separately represented by an attorney, the health care Plan and the covered member, by their attorneys, may enter into an agreement regarding allocation of the covered member's cost, disbursements, and reasonable attorney fees and other expenses. If the health care Plan and the covered member cannot reach agreement on allocation, the health care Plan and the covered member shall submit the matter to binding arbitration.

Notice Requirement

You must provide timely written notice to the health care Plan of the pending or potential Claim if you make a Claim against a third party for damages that include repayment for medical and medically related expenses incurred for your benefit. The Plan Administrator, at its option, may take appropriate action to preserve its rights under this Reimbursement and Subrogation section, including the right to intervene in any lawsuit you have commenced.

The Plan Administrator may delegate such functions to the Claims Administrator.

Duty to Cooperate

You must cooperate with the Plan Administrator in assisting it to protect its legal rights under this provision. You agree that the limited period in which the health care Plan may seek reimbursement or to subrogate does not commence to run until you or your attorney has given notice to the health care Plan of your Claim against a third party.

Identification Card

If your card is lost or stolen, please contact Member Service immediately. You can also request additional or replacement cards online by logging onto www.bluecrossmnonline.com.

How to File a Claim

Network Providers file your Claims for you. If you use an Out-of-Network Provider, however, you may have to file the Claim yourself. If you notify the Claims Administrator of a Claim they will send you a Claim form within 15 days. If the Claims Administrator fails to send you a Claim form within 15 days your Claim will be treated as if you had submitted all required proof of loss documentation. Claim forms are also available on the Claims Administrator's website at www.bluecrossmn.com or by calling Member Service at the telephone number on the back of your member ID card. You must file a written Claim within 90 days after a Covered Service is provided. If this is not reasonably possible, Claims are accepted for up to 12 months after the date of Service. Normally, failure to file a Claim within the required time limits will result in denial of your Claim. These limits are waived, however, if you cannot file the Claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

You will receive a written notice of the decision on your Claim with 30 business days after the Claim and any other required information is received.

Right of Examination

The Claims Administrator has the right to ask you to be examined by a provider during the review of any Claim. The Claims Administrator chooses the provider and pays them for the exam whenever this is requested. Failure to comply with this request may result in denial of your Claim.

No Third Party Beneficiaries

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

Release of Records

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

Your Explanation of Benefits Statement

When you submit a Claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by the Claims Administrator;
- the Copayment; Deductible and Coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a Claim because, for example, the Network Provider will submit the bill as a Claim for payment under its contract with the Claims Administrator, you will receive an EOB only when you are required to pay amounts other than your required Copayment.

If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Member Service at the telephone number listed on the back of your member ID card.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding Network Providers, coverage, operations or management policies, please contact Member Service at the telephone number listed on the back of your member ID card or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

Blue Cross and Blue Shield of Minnesota
P.O. Box 64179
St. Paul, MN 55164-0179

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by the Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Member Service at the telephone number listed on the back of your member ID card.

Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting Claims for Services that you did not get; Adding extra charges for Services that you did not get; giving you Treatment for Services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a Claim, and should be made by directly contacting Member Service at the telephone number listed on the back of your member ID card.

Filing Benefit Claims

Authorized Representatives

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-Service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Requests for Precertification and Other Pre-Service Claims

For a description of how to file a request for Precertification or other Pre-Service Claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

Requests for Reimbursement and Other Post-Service Claims

When a Hospital, Physician or other provider submits its own reimbursement Claim, the amount paid to that provider will be determined in accordance with the provider's agreement with the Claims Administrator or the local licensee of the Blue Cross Blue Shield Association serving your area. The Claims Administrator will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a Copayment, Coinsurance or Deductible will also be identified in that EOB or notice. If you believe that the Copayment, Coinsurance or Deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your health care Plan, you may file a Claim with the Claims Administrator. For instructions on how to file such Claims, you should contact Member Service at the telephone number listed on the back of your member ID card.

Determinations on Benefit Claims

Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims

For a description of the time frames in which requests for Precertification or other Pre-Service Claims will be determined by the Claims Administrator and the notice you will receive concerning its decision, whether adverse or not, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims

The Claims Administrator will notify you in writing of its determination on your request for reimbursement or other post-Service Claim within a reasonable period of time following receipt of your Claim. That period of time will not exceed 30 days from the date your Claim was received. However, this 30-day period of time may be extended one time by the Claims Administrator for an additional 15 days, provided that the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your post-Service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-Service Claim.

If your request for reimbursement or other post-Service Claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-Service Claim, see the Appeal Procedure subsection below.

Exception Requests for Clinically Appropriate Prescription Drugs Not Covered by this Plan

If the prescribing health care professional believes that you need coverage for a clinically appropriate drug that is not covered by this Plan, there is a process to request an exception. You, your designee, or the prescribing health care professional must submit an exception request to us. There are two types of exception requests for clinically appropriate drugs not covered by this Plan: 1) standard exception requests; and, 2) expedited exception requests based on exigent circumstances. If an exception request is approved, whether upon our initial determination or following external review by the Independent Review Organization (IRO) (as described below in this section), coverage will be provided as follows: (i) for approved standard requests, coverage will be provided for the duration of the prescription; (ii) for approved expedited requests based on exigent circumstances, coverage will be provided for the duration of the exigency.

Independent Review Organization (or IRO) means an entity authorized to conduct independent external reviews of denied requests for standard or expedited exceptions for drugs not otherwise covered by this Plan.

Standard Exception Requests

We will review standard requests and notify the enrollee or his/her designee and the prescribing Health Care Provider of our determination within 72 hours of receiving the request. We will promptly grant an exception to the formulary when the formulary drug causes an adverse reaction, when the formulary drug is contraindicated, or when the prescriber demonstrates that a Prescription Drug must be dispensed as written to provide maximum medical benefit to you.

Expedited Exception Requests Based on Exigent Circumstances

Expedited requests may be made when "exigent circumstances" exist. "Exigent circumstances" may exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of Treatment using a non-preferred drug. We will review requests that meet the criteria for expedited review and notify the enrollee or his/her designee and the prescribing Health Care Provider of our determination within 24 hours of receiving the request.

External Review of a Standard or Expedited Exception Request

If we deny your request for a standard or expedited exception for a clinically appropriate drug that is not covered by this Plan, you may request that our determination be reviewed by an IRO. The enrollee or his/her designee and the prescribing Health Care Provider will be notified of the IRO determination as follow:

- If the original request was a standard exception request, within 72 hours of receiving the request for external review; or,
- If the original request was an expedited exception request based on exigent circumstances, within 24 hours of receiving the request for external review.

You also have the right to External Review. Please refer to the "External Review" under the "Appeal Process" section.

Appeal Process

Introduction

As described below, the Claims Administrator has two different processes to resolve appeals: one for appeals that do not require a medical determination; and, one for appeals that do require a medical determination. With an exception described below, you are required to submit a first level appeal before you can exercise any other rights to appeal or other review. If the decision on that first level review is wholly or partially adverse to you, you may either file a second level appeal within the Claims Administrator or you may seek review external to the Claims Administrator. If you choose to file a second level appeal within the Claims Administrator, and that decision is wholly or partially adverse to you, you can then seek external review. There is an exception for cases that qualify for an expedited appeal. For those cases, you may seek external review at the same time you request an expedited first level appeal.

You can call or write the Claims Administrator with your appeal. You will be sent an appeal form upon request. If you need assistance, the Claims Administrator will complete the written appeal form and mail it to you for your signature. The Claims Administrator will work to resolve your appeal as soon as possible using the appeal process outlined below.

In addition, you may file your appeal with the Minnesota Commissioner of Commerce at any time by calling 651-539-1600 or toll free 1-800-657-3602. If you are covered under a Plan offered by the State Health Plan, a city, county, school district, or Service cooperative, you may also contact the U.S. Department of Health and Human Services Insurance Assistance Team at 888-393-2789.

Definitions

Adverse Benefit Determination means a decision relating to a health care Service or Claim that is partially or wholly adverse to the complainant.

Appeal means any grievance that is not the subject of litigation concerning any aspect of the provision of health Services under this booklet. If the appeal is from an applicant, the appeal must relate to the application. If the appeal is from a former member, the appeal must relate to the provision of health Services during the period of time the appellant was a member. Any appeal that requires a medical determination in its resolution must have the medical determination aspect of the appeal processed under the utilization review process described below.

Appellant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits an appeal.

Member means an individual who is covered by a health benefit Plan.

First Level Appeals That Do Not Require a Medical Determination

First Level Oral Complaint

If you call or appear in person to notify the Claims Administrator that you would like to file a complaint, the Claims Administrator will try to resolve your oral complaint as quickly as possible. However, if the Claims Administrator's resolution of your oral complaint is wholly or partially adverse to you, or not resolved to your satisfaction, within 10 days of receipt of your oral complaint, you may submit a first level appeal in writing. The Claims Administrator will provide you an appeal form on which you can include all the necessary information to file your written appeal. If you need assistance, the Claims Administrator will complete the written appeal form and mail it to you for your signature. You must tell the Claims Administrator all reasons and arguments in support of your appeal, and you must identify and provide all evidence in support of your appeal unless that evidence is already in the Claims Administrator's possession.

First Level Written Appeals

If the Claims Administrator decides a Claim that is wholly or partially adverse to you, and you wish to appeal, you are required to submit a first level appeal. You may submit your appeal in writing, or you may request an appeal form on which you can include all the necessary information to file your appeal. Your appeal must state all reasons and arguments in support of the appeal, and you must submit all evidence in support of your appeal unless that evidence is already in the Claims Administrator's possession. The Claims Administrator will notify you that they have received your written appeal.

The Claims Administrator will inform you of their decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If the Claims Administrator is unable to make a decision within 30 days due to circumstances outside the Claims Administrator's control, the Claims Administrator may take up to 14 additional days to make a decision. If the Claims Administrator takes more than 30 days to make a decision, the Claims Administrator will inform you of the reasons for the extension. You have the right to review the information that the Claims Administrator relied on in the course of the appeal.

First Level Appeals that Require a Medical Determination

When a medical determination is necessary to resolve your appeal, the Claims Administrator will process your appeal using these utilization review appeal procedures. Utilization review applies a well-defined process to determine whether health care Services are Medically Necessary and Appropriate and eligible for coverage. Utilization review includes a process to appeal decisions not to cover a health care Service. This utilization review process is found under "Medical management" in the "Health Care Management" section, If we deny your requested Service the denial letter will describe the process for initiating an appeal.

Utilization review applies only when the Service requested is otherwise covered under this health care Plan.

In order to conduct utilization review, the Claims Administrator will need specific information. If you or your Attending Health Care Provider do not release necessary information, approval of the requested Service, procedure, or Admission to a Facility provider may be denied.

Definitions

Attending Health Care Provider means a health care professional with primary responsibility for the care provided to a sick or injured person.

Concurrent review means utilization review conducted during a member's Hospital stay or course of Treatment.

Determination not to certify means that the Service you or your provider has requested has been found to not be Medically Necessary and Appropriate or efficacious under the terms of this health care Plan.

Prior Authorization means utilization review conducted prior to the delivery of a Service, including an outpatient Service.

Provider means a health care professional or Facility provider licensed, certified or otherwise qualified under state law, in the state in which the Services are rendered, to provide the health Services billed by that provider. Provider also includes pharmacies, medical Supply companies, independent laboratories, and ambulances.

Utilization review means the evaluation of the necessity, appropriateness, and efficacy of the use of health care Services, procedures and facilities, by a person or entity other than the attending Health Care Provider, for the purpose of determining the medical necessity of the Services or Admission.

Standard First Level Appeal

You or your Attending Health Care Provider may appeal the Claims Administrator's initial determination to not certify Services in writing or by telephone. The decision on this first level appeal will be made by a Health Care Provider who did not make the initial determination. The Claims Administrator will notify you and your Attending Health Care Provider of their decision within 30 days of receipt of your appeal. If the Claims Administrator is unable to make a decision within 30 days due to circumstances outside their control, the Claims Administrator may take up to 14 additional days to make a decision. If the Claims Administrator takes more than 30 days to make a decision, the Claims Administrator will inform you of the reasons for the extension. You have the right to review information relied on in making the initial determination.

Expedited First Level Appeal

When the Claims Administrator's initial determination to not certify a health care Service is made prior to or during an ongoing Service requiring review and the Attending Health Care Provider believes that an expedited appeal is warranted, you and your Attending Health Care Provider may request an expedited appeal. You and your Attending Health Care Provider may appeal the determination over the telephone. The Claims Administrator's appeal staff will include the consulting Physician or Health Care Provider if reasonably available. When an expedited appeal is completed, the Claims Administrator will notify you and your Attending Health Care Provider of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from the Claims Administrator's

receipt of the expedited appeal request. If the Claims Administrator declines to reverse their initial determination not to certify, you will be notified of your right to submit the appeal to the external review process described below.

Second Level Appeals to Blue Cross Internal Appeals Committee

If the Claims Administrator's final decision on your first level appeal is wholly or partially adverse to you, you may appeal their final decision through External Review, as described below. Alternatively, you may voluntarily appeal to the Claims Administrator's internal appeals committee (second level appeal), as described in this section, before seeking External Review. If you appeal to the Claims Administrator's internal appeals committee, you may either have the appeal decided solely on the written submissions or you may request a hearing in addition to your written submissions. You may receive continued coverage pending the outcome of the appeals process. You may request a form that on which you can include all the information necessary for your appeal. During the course of the Claims Administrator's review, the Claims Administrator will provide you with any new evidence that the Claims Administrator considers or relies upon, as well as any new rationale for a decision. If the Claims Administrator's decision is wholly or partially adverse to you, the notice will advise you of how to submit the decision to External Review as described below. If you request, the Claims Administrator will provide you a complete summary of the appeal decision.

The request for a first, and any second, level appeal should include:

- the member's name, identification number and group number
- the actual Service for which coverage was denied
- a copy of the denial letter
- the reason why you or your Attending Health Care Provider believe coverage for the Service should be provided
- any available medical information to support your reasons for reversing the denial
- any other information you believe will be helpful to the decision maker

The Claims Administrator will notify you that they have received your second level appeal. You may present evidence in the form of written correspondence, including explanations or other information from you, staff persons, administrators, providers, or other persons. If your appeal is decided solely on the written submissions, you may also present testimony by telephone to an Appeal Liaison.

Within 30 days of receiving your second level appeal and all necessary information, the Claims Administrator will notify you in writing of their decision and the reasons for the decision. If you request, the Claims Administrator will provide you a complete summary of the appeal decision.

If you request a hearing, you or any person you choose may present testimony or other information. The Claims Administrator will provide you written notice of their decision and all key findings within 45 days after the Claims Administrator receives your written request for a hearing.

External Review

You must exhaust your first level appeals option prior to requesting External Review unless: 1) the Claims Administrator waives the exhaustion requirement in writing; 2) the Claims Administrator substantially fails to comply with required procedures; or, 3) you qualified for and applied for an Expedited First Level Appeal of a medical determination and applied for an Expedited External Review at the same time.

If your appeal concerns a complaint decision relative to a health care Service or Claim and you believe the Claims Administrator's appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf may submit the appeal to external review. You must request External Review within six (6) months from the date of the adverse determination. External review of your appeal will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Commerce along with a $25 filing fee. You will not be subject to filing fees totaling more than $75 per policy year. The Commissioner may waive the fee in cases of financial hardship. The Claims Administrator will refund the fee if their determination is reversed by the external reviewer.

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

The external review entity will notify you and the Claims Administrator that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and the Claims Administrator

must provide the external review entity any information to be considered. Both you and the Claims Administrator will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, the Claims Administrator, and the Commissioner within 45 days of receiving the request for external review. The external review entity's decision is binding on the Claims Administrator, but not binding on you.

Expedited External Review

Expedited external review will be provided if you request it after receiving an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have simultaneously requested an expedited internal appeal. Expedited external review will also be provided after receiving an adverse benefit determination that concerns (i) an Admission, availability of care, continued stay, or health care Services for which you received emergency Services but have not yet been discharged from a Facility provider; or, (ii) a medical condition of which the standard external review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

The external review entity must make its expedited determination to uphold or reverse the adverse benefit determination as expeditiously as possible but within no more than 72 hours after receipt of the request for expedited review and notify you and the Claims Administrator of the determination. If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

The appeals and determination processes described above are subject to change if required or permitted by changes in state or federal law governing appeal procedures.

Member Service

Whether it is for help with a Claim or a question about your benefits, you can call your Member Service telephone number or log onto the Claims Administrator's member website both located on the back of your ID card.

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

The Member Service staff will provide interpreter Services to assist you if needed. This includes spoken language and hearing interpreters.

Privacy of Protected Health Information

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

Restrictions on the Use and Disclosure of Protected Health Information

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

Separation Between the Employer and the Plan

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

- Benefits Administrator

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

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

Terms You Should Know

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive Inpatient Care in a Facility.

Accountable Care Organization (ACO) - A group of Physicians, other health care professionals, Hospitals, and other Health Care Providers that accept a shared responsibility to deliver a broad set of medical Services to a defined set of patients.

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.).

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

Allowed Amount - The amount that payment is based on for a given Covered Service of a specific provider. The Allowed Amount may vary from one provider to another for the same Service. All benefits are based on the Allowed Amount, except as specified in the "Summary of Benefits." For Network Providers, the Allowed Amount is the negotiated amount of payment that the Network Provider has agreed to accept as full payment for a Covered Service at the time your Claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your Claim is processed for Covered Services at Network Providers as a result of expected settlements or other factors. The negotiated amount of payment with Network Providers for certain Covered Services may not be based on a specified charge for each Service. Through annual or other global settlements, rebates, prospective payments or other methods, the Claims Administrator may adjust the amount due to Network Providers without reprocessing individual Claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your Claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Claims Administrator, and the percentage of the Allowed Amount paid by the Claims Administrator is lower than the stated percentage for the Covered Service. If the payment to the provider is increased, the Claims Administrator pays that cost on your behalf, and the percentage of the Allowed Amount paid is higher than the stated percentage.

The Allowed Amount for All Nonparticipating Providers

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

The Allowed Amount for Nonparticipating Providers In Minnesota

For Nonparticipating Provider Services within Minnesota, except those described under Special Circumstances below, the Allowed Amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage of billed charges; or, (3) pricing based upon 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. When the Medicare Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by the Claims Administrator.

The Allowed Amount for Nonparticipating Provider Services Outside Minnesota

For Nonparticipating Provider Physician or clinic Services outside of Minnesota, except those described under Special Circumstances below, the Allowed Amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield Plan; or, (4) pricing based upon 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. When the Medicare Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by the Claims Administrator.

Special Circumstances

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a Medical Emergency. Some Hospital-based providers (e.g., anesthesiologists) may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the Allowed Amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. The extent of reimbursement in certain Medical Emergency circumstances may also be subject to state and federal law - please refer to "Emergency Care" for coverage of benefits.

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 Member Service at the telephone number listed on the back of your member ID card for more information.

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

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

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, Artificial Insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

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

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care Services while traveling outside of your Service Area. You must use Network Providers of a Host Blue and show your member ID card to secure BlueCard Program access.

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

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

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

Care/Case Management Plan - A plan for health care Services developed for a specific patient by a care/case managers 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.

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

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

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

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

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

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

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.

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

Deductible - The Deductible is a specified dollar amount you must pay for most Covered Services each Calendar Year before the health care Plan begins to provide payment for benefits. Services such as prenatal care, Pediatric Preventive Care, and Primary Network Preventive Care Services for adults are not subject to the Deductible. See the "Summary of Benefits" section for the Deductible amount. The dollar amount reimbursed or paid by a Coupon will not count toward your Deductible.

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

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

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

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

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

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

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

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, a Home Health Agency, or freestanding birthing center when Services are billed on a Facility Claim.

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

Generic Drug - A Prescription Drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a Brand Drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by the Claims Administrator.

Group Contractholder - The employer or association to which the group contract is issued.

Group Member - The employee, association member or employee, shareholder or employee for whom coverage has been provided by the Group Contractholder or association.

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

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

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

Home Health Agency - A Medicare-approved or other preapproved Facility that sends health care professionals and home health aides into a person's home to provide health Services.

Hospice Care - A coordinated set of Services provided at home or in an inpatient Hospital setting for covered individuals 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.

Host Blue - A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Network Providers in its designated Service Area that require such Network Providers to provide Services to members of other Blue Cross and/or Blue Shield organizations.

Illness - A sickness, injury, pregnancy, Mental Illness, Substance Abuse, or condition involving a physical disorder.

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

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

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.

Lifetime Maximum - The cumulative maximum payable for Covered Services incurred by a member during their lifetime or by each covered Dependent during their lifetime under all health care Plans with the employer. The Lifetime Maximum does not include amounts which are the member’s responsibility, such as Deductibles, Coinsurance, Copayments, and other amounts. Refer to the "Summary of Benefits" section for specific dollar maximums on certain Services.

Mail Service Pharmacy - A pharmacy that dispenses Prescription Drugs through the U.S. Mail.

Maintenance Prescription Drug - A Maintenance Prescription Drug, which the Claims Administrator is contractually obligated to pay or provide as a benefit to you under this health care Plan when dispensed by a participating maintenance pharmacy. Any prescription order for not more than a 90-day Supply of a legend Prescription Drug shall be considered a Maintenance Prescription Drug, unless otherwise expressly excluded.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are Medically Necessary and Appropriate and part of specialized therapy for the member's condition.

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

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

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

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

Methadone Maintenance - The Treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

Network - Depending on where you receive Services, the Network is designated as one of the following:

- When you receive Services within the health care Plan Service Area, the designated Network for professional providers and Facility providers is the Aware Network.
- When you receive Services within the Claims Administrator's Service Area, the designated Network for professional providers and Facility providers is the Aware Network.
- When you receive Services outside Minnesota, the designated participating Network for professional providers and Facility providers is the local Traditional Network.

Network Provider - An ancillary provider, professional provider or Facility provider who has entered into an agreement, either directly or indirectly, the Claims Administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a Network for Covered Services rendered to a member.

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 who has not entered into a Network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.

Out-of-Network Participating Provider **-** Providers who have a contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan (Participating Providers), but are not Network Providers because the contract is not specific to this Plan.

Out-of-Network Provider - A Provider with a Blue Cross contract that is not specific to this plan; and, Nonparticipating Providers.

Out-of-Pocket Limit - The Out-of-Pocket Limit refers to the specified dollar amount of member cost-sharing incurred for Covered Services in a Calendar Year. When the specified dollar amount is attained, the Claims Administrator begins to pay 100% of the Allowed Amount for all covered expenses. See your "Summary of Benefits" section for the Out-of-Pocket Limit. The dollar amount reimbursed or paid by a Coupon will not count toward your Out-of-Pocket Limit.

Outpatient Behavioral Health Treatment Facility - A Facility that provides outpatient Treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse, or 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 Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care Services or Substance Abuse Services on a planned and regularly scheduled basis in a Facility provider designed for a member or client who would benefit from more intensive Services than are generally offered through outpatient Treatment but who does not require Inpatient Care.

Participating Pharmacy - A pharmaceutical Provider that participates in a Network for the dispensing of Prescription Drugs.

Participating Provider - A Provider who has entered into either a specific Network contract or a general broader Network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.

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

Place of Service - Industry standard Claim submission standards (established by the Medicare program) used by clinic and Hospital providers.

Plan - The Plan of benefits established by the Plan Administrator.

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

Precertification (Preauthorization/Prior Authorization) - The process through which selected Covered Services are pre-approved by the Claims Administrator.

Preferred Drug List - The Claims Administrator’s Preferred Drug List is an extensive list of Food & Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The List was developed by the Claims Administrator’s Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee.

Prescription Drug List – Your designated Prescription Drug List is an extensive list of Food & Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The List was developed by the Claims Administrator's Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee.

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.

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

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A Facility licensed under state law in the state in which it is located that provides inpatient 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 member when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment or worksite that 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 Facility provider. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible Health Care Providers that have a practice arrangement with a Physician. The list of available medical Services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic Services is available on a walk-in basis.

Retail Pharmacy - Any licensed pharmacy that you can physically enter to obtain a Prescription Drug.

Services - Health care Services, procedures, Treatments, Durable Medical Equipment, medical supplies, and Prescription Drugs.

Skilled Care - Services rendered other than in a Skilled Nursing Facility that are Medically Necessary and Appropriate 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(s) of combined Services that include non-Skilled Care are covered under the Plan.

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

Skilled Nursing Care - Intermittent Hours - Intermittent skilled nursing Services consist of up to two (2) consecutive hours per date of Service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved Home Health Care Agency.

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.

Specialist - A Physician who limits his or her practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty Drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, Provider coordination, or patient education that cannot be provided by a Retail Pharmacy. Specialty Drugs are drugs including, but not limited to drugs used for: Infertility; growth hormone Treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and, hemophilia.

Specialty Pharmacy Network - A nationwide pharmaceutical specialty provider that participates in a Network for the dispensing of certain oral medications and injectable drugs.

Step Therapy - Step Therapy includes, but is not limited to medications in specific categories or drug classes. If your Physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication in the same or different drug class before the Step Therapy medication will be paid under the drug benefit.

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

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

Supply - Equipment that must be Medically Necessary and Appropriate for the medical Treatment or diagnosis of an Illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.
Supplies do not include such things as:

1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; and,
6. informational materials.

Telemedicine Services - Telemedicine Services may also be referred to as televideo consultations or telehealth Services. These Services are interactive audio and video communications, permitting real-time communication between a distant site Physician or practitioner and the member, who is present and participating in the televideo visit at a remote Facility.

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

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

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

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

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

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

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