# St Louis County
# Self Insured Plan

**PPO**

**PLEASE READ YOUR BOOKLET CAREFULLY**

# Language Access Services

**This notice has important information about your health plan coverage.** If you, or someone you're helping, has questions about this health plan coverage, you can receive help and information in your language at no cost. To talk to an interpreter, call 1-800-382-2000 (toll free).

**Este aviso tiene información importante sobre su solicitud o cobertura del plan de salud**. Busque fechas clave en este aviso. Es posible que deba tomar medidas antes de ciertos plazos para mantener su cobertura o recibir ayuda con los costos. Si usted, o alguien a quien esté ayudando, tiene preguntas sobre este aviso o sobre la cobertura del plan de salud, puede recibir información y ayuda en su idioma sin costo. Para comunicarse con un intérprete, llame al número gratuito 1-855-903-2583.

**Tsab ntawv ceeb toom no muaj cov lus tseem ceeb hais txog koj daim ntawv thov los yog qhov kev pab them rau koj daim phiaj npaj kho mob.** Saib cov hnub tseem ceeb nyob hauv daim ntawv ceeb toom no. Tej zaum koj yuav tau ua qee yam kom tiav ua ntej qee cov hnub uas teev rau hauv no kom thiaj tsis poob qhov kev pab them los yog kom tau txais kev pab them cov nqi kho mob. Yog hais tias koj, los yog lwm tus uas koj pab, muaj lus nug txog tsab ntawv ceeb toom no los yog qhov kev pab them rau daim phiaj npaj kho mob, koj muaj cai tau txais kev pab thiab ntaub ntawv ua koj hom lus yam tsis tau them nyiaj dab tsi. Yog xav tham nrog ib tus neeg pab txhais lus, hu rau tus xov tooj 1-800-793-6931 (hu dawb).

**Ogeysiiskani wuxuu wataa macluumaad muhiim ah oo ku saabsan caynsanaanta qorshahaaga caafimaad.**U fiirso taariikhaha ku yaal ogeysiiskan.Waxa laga yaabaa inaad u baahto ficil ka qaad taariikhaha kama dambayska ah si aad u sii haysto caynsanaantaada ama aad ugu hesho caawimo kharashyada.Haddii adiga, ama qof aad caawinayso, u ka qabo su'aalo arrimaha ku saabsan ogeysiiskan ama caynsanaanta qorshaha caafimaadka, waxaad ku heli kartaa caawimo iyo macluumaad luqaddaada iyada oo aan kharash kaa bixin.Si aad ula hadasho turjumaan, soo wac 1-866-251-6736 (lacag la'aan).

**Beeksis kun waayee iyyannoo keetii ykn kan karoorri fayyaa kee qabaachuu malu odeeffannoo barbaachisaa qaba.** Guyoota futuu ta'an achi keessa ilaali. Insuraansiin kee akka addaan hincinnee fi basii tokko tokkoof gargaarsa argachuudhaaf, yeroon utuu itti hindarbin tarkaanfii fudhachuu qabda . Ati ykn nami ati gargaaraa jirtu yoo waayee beeksisakana ykn karoora fayyaa kana kee hanga inni ga'u gaaffii qabaattan, kaffaltii malee gargaarsaa fi odeeffannoo afaan keessaniin argachuu dandeessu. Nama afaan isinii hiiku waliin haasa'uudhaaf 1-855-315-4016 (lak. Tolaa bilbila'a).

**Thông báo này có thông tin quan trọng về đơn đăng ký hoặc phạm vi bao trả theo chương trình sức khỏe của quý vị.** Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì phạm vi bao trả hoặc được giúp đỡ có tính phí. Nếu quý vị, hoặc người quý vị đang giúp đỡ, có thắc mắc về thông báo này hoặc phạm vi bao trả theo chương trình sức khỏe của quý vị, quý vị có thể nhận giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 1-855-315-4015 (miễn phí).

**本通知包含與您申請或健康計劃承保有關的重要資訊**。請注意本通知中的重要日期。您可能需要在特定期限之前採取行動才能維持承保或取得費用補助。如果您本人或您協助的對象對本通知或健康計劃承保有疑問，您可免費以您的語言取得協助和資訊。如欲與口譯員交談，請致電 1-855-315-4017（免費電話）。

**В этом уведомлении содержится важная информация** о Вашей заявке на включение в план или страховом покрытии, предоставляемом планом медицинского страхования. Обратите внимание на даты, приведенные в этом уведомлении. Для того чтобы сохранить страховку или получить помощь в связи с какими-либо выплатами, Вам, возможно, потребуется к определенному сроку предпринять какие-то действия. Если у Вас или у кого-то, кто Вам помогает, появятся вопросы по поводу этого уведомления или предоставляемого планом страхового покрытия, Вы можете бесплатно получить помощь и информацию на Вашем родном языке. Чтобы связаться с переводчиком, позвоните по телефону 1-855-315-4028 (звонки бесплатные).

**ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງໃນແຜນປະກັນສຸຂະພາບຂອງທ່ານ.** ຊອກເບິ່ງວັນທີສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານໄວ້ ຫຼື ເພື່ອຮັບເອົາການຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍ. ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບແຈ້ງການນີ້ ຫຼື ຄວາມຄຸ້ມຄອງໃນແຜນປະກັນສຸຂະພາບ, ທ່ານສາມາດຮັບເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-866-356-2423 (ເບີໂທເກັບເງິນປາຍທາງ).

**ይህ ማስታወቂያ ማመልከቻዎን ወይም የጤና ዕቅድ ሽፋንዎን በተመለከተ አስፈላጊ መረጃ አለው።** በዚህ ማስታወቂያ ውስጥ ዋናዋና የሆኑ ቀናትን ይመልከቱ። የእርስዎ የጤና እቅድ ሽፋን እንዲቀጥል ወይም ዋጋው በሚመለከት እርዳታ ለማግኘት በተወሰኑ ቀነ ገደቦች እርምጃ መውሰድ ይኖርብዎታል። እርስዎ ወይም እርስዎ የሚረዱት ሰው ይህን ማስታወቂያ ወይም የጤና እቅድ ሽፋን በሚመለከት ጥያቄ ካላችሁ፤ ምንም ወጪ ሳታወጡ በራሳችሁ ቋንቋ እርዳታ እና መረጃ ማግኘት ትችላላችሁ። ከአስተርጓሚ ጋር ለመነጋገር በስልክ ቁጥር 1-855-315-4030 (በነጻ) ይደውሉ።

**တtill ဘာသာ**ညွှန်ကြားချက် **ဤ**အရေးကြီး**သော**အရေးပါ**သော** ဘာ**သား** **နတ်**ပတ်**ထိ**ခ် **မ**ူတမ်**း** **တ**ိုးတက်**ရ**ေ**အ**ာ**ရှ**ိခ် ဘာ**သား** **နတ်**ပတ်**ထိ**ခ် **မ**ူတမ်**း** **တ**ိုးတက်**ရ**ေ**အ**ာ**ရှ**ိခ် **ကိ**ုယ်**လ**ီ**း**. ကျွ**နုပ်**နဲ့**အ**ရေ**ဖ**ိခ် **လ**ေ**တ**ိ**ဘ**ီ**း** **သ**ွ**ဉ်**ညွှ**နိ**ခ်**အ**ေ**အ**ပူ**အ**ဂီ**တ**ကျ**နော်**. **နက**ာ**ဘ**ာ် **ဟ**ီ**း**ဝ**ါ**ဝ**ီ**မ**ေ**တ**ာ် **တ**နီ**း**လ**ေ **က**ပ**ေ**ဃာ**နတ**ာ်**အ**ုဉ်**ကီ**း **မ**ူတမ်**း** **ဖ**ီ**း**နှ**ါ**ဘ**ဉ်**တ**ာ်**မ**ေ**စ**ေ**လ**ေ**တ**ာ်**အ**ိဉ်**ရ**ူဉ်**အ**ိဉ်**ရ**ျ**အ**ဂီ**လ**ီ**း**. **နဖ**ီ**း**နှ**ါ** **တ**ာ်**မ**ေ**စ**ေ**ဖ**ီ**း** **တ**ာ်**ဝ**ါ**တ**ာ်**က**ျိ**ုလ**ေ**နနှ**ီ**ါ**က**စ**ါ**အ**ကျ**ိ**ဉ်**သ**ွ **လ**ေ**တ**အ**ိဉ်**ဖ**ီ**း**တ**ာ်**လ**ာ**ဉ်**ဘ**ူ**ဉ်**လ**ာ**ဉ်**စ**ု**ေ **ဖ**နေ**, **မ**ူတမ်**း** **ပ**ုေ**တ**ဂ**ေ**ဂ**ေ**လ**ေ**နမ**ေ**စ**ေ**, **မ**ှ**အ**ိဉ်**ဖ**ီ**း**တ**ာ်**သ**ံ**ကွ**ာ်**ဘ**ဉ်**ဃ**ီ**း**တ**ာ် **ဘ**ီ**း**သ**ွ**ဉ်**ညွှ**နိ**ခ်**အ**ေ **မ**ူတမ်**း** **တ**ာ်**အ**ိဉ်**ရ**ူဉ်**အ**ိဉ်**ရ**ျ**တ**ာ်**တ**ာ်**ဘ**ာ်**က**ျ**ေ**တ**ာ်**အ**ုဉ်**ကီ**း**နှ**ဉ်**လ**ီ**း**. **က**ီ**း**လ**ီ**တ**ဲ**စ**ိ**ရ**ူ 1-866-251-6744 (**လ**ီ**တ**ဲ**စ**ိ**က**လ**ီ**), **လ**ေ**က**က**တ**ီ**း**သ**က**ီ**း** **တ**ာ်**ဖ**ီ**း**ပ**ုေ**က**ျ**ိ**ုထ**ံ**တ**ာ်**အ**ဂီ**တ**ကျ**ု**.

**Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder zur Abdeckung durch Ihren Gesundheitsschutzplan.** Beachten Sie wichtige Daten in dieser Mitteilung. Sie müssen unter Umständen innerhalb gewisser Fristen bestimmte Handlungen ergreifen, damit Ihre Abdeckung bestehen bleibt oder Sie Kostenunterstützung erhalten. Wenn Sie oder eine Person, die Ihnen zur Seite steht, Fragen zu dieser Mitteilung oder zur Abdeckung durch den Gesundheitsschutzplan haben, können Sie kostenlos Hilfe und Informationen in Ihrer Muttersprache erhalten. Um mit einem Dolmetscher zu sprechen, wählen Sie 1-866-289-7402 (gebührenfrei).

**កំណត់សម្គាល់នេះមានព័ត៌មានសំខាន់អំពីការដាក់ពាក្យ**
ឬការគ្របដណ្ដប់នៃគម្រោងសុខភាពរបស់អ្នក។ រកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងកំណត់សម្គាល់នេះ។ អ្នកអាចត្រូវការចាត់វិធានការត្រឹមកាលបរិច្ឆេទផ្ទុតកំណត់ជាក់លាក់នានាដើម្បីរក្សាការគ្របដណ្ដប់របស់អ្នក ឬដើម្បីទទួលបានជំនួយជាមួយថ្លៃចំណាយផ្សេងៗ។ ប្រសិនបើអ្នក
ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពីកំណត់សម្គាល់នេះ
ឬការគ្របដណ្ដប់នៃគម្រោងសុខភាព អ្នកអាចទទួលបានជំនួយ
និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែផ្ទាល់មាត់
សូមទូរស័ព្ទទៅលេខ 1-855-906-2583 (លេខឥតគិតថ្លៃ)។

**يتضمن هذا الإشعار معلومات مهمة حول الطلب الذي تقدمت به أو تغطية برنامجك الصحي.** ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يكون عليك اتخاذ إجراء ما بحلول مواعيد نهائية معينة للاحتفاظ بتغطيتك أو لتلقي المساعدة فيما يتعلق بالتكاليف. إذا كانت لديك أنت، أو شخص ما تقوم بمساعدته، أي أسئلة حول هذا الإشعار أو تغطية البرنامج الصحي، فيمكنك الحصول على المساعدة والمعلومات بلغتك الأم دون أي تكلفة. للتحدث إلى أحد المترجمين الفوريين، اتصل بالرقم 1-866-569-9123 (رقم مجاني).

**Cet avis contient des informations importantes concernant votre application ou votre assurance maladie.** Recherchez les dates-clés dans cet avis. Il se peut que vous deviez réagir avant certaines dates limites pour conserver votre couverture ou recevoir une aide pour vos frais. Si vous-même ou la personne que vous aidez avez des questions concernant cet avis ou l'assurance maladie, vous pouvez recevoir de l'aide et des informations dans votre langue gratuitement. Pour parler à un interprète, appelez le 1-855-315-4029 (appel gratuit).

**본 통지서에는 귀하의 보험 가입이나 의료 보험 적용 범위에 대한 중요한** 정보가 담겨 있습니다. 본 통지서에 나와 있는 중요한 날짜를 확인해 보십시오. 귀하께서는 특정 마감 기한까지 조치를 취하셔야 계속 보험 적용을 받거나 비용 지원을 받으실 수 있습니다. 귀하 본인이나 귀하가 도와주고 있는 사람이 본 통지서나 의료 보험 적용 범위에 대한 질문이 있는 경우, 본인| 비용 부담 없이 모국어로 지원 및 정보를 받으실 수 있습니다. 통역사와 통화를 하시려면, 1-855-904-2583 번(수신자 부담)으로 연락하시기 바랍니다.

**Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw ng planong pangkalusugan.** Maghanap ng mahahalagang petsa sa paunawang ito. Maaaring kailanganin mong gumawa ng aksyon sa pamamagitan ng ilang mga itinakdang panahon upang mapanatili ang iyong saklaw o makatanggap ng tulong para sa mga gastos. Kung ikaw, o ang isang tao na tinutulungan mo, ay may mga katanungan tungkol sa paunawang ito o saklaw ng planong pangkalusugan, makatatanggap ka ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang taga-interpret, tumawag sa 1-866-537-7720 (walang bayad ang toll).

**Díí éí nits'íís baa áháyą binaaltsoos dóó bee nik'i adéest'í'ígí aláahgo binahjį' ééhózinígí át'é.** Yoołkáá dabiká'ígí baa ákonínízin dooleeł. Łahda t'áadoo áajį' iiłkááhí éí díí naaltsooshazhdiil'ı́ı́h díí shá bik'é azláadoo jinízingo. Ni éí doodagóó t'áá háída biká'anilyeedígí díí naaltsoos dóó bik'é azláhígí bąąh na'ídíkid neehólǫǫgo éí t'áájíík'e t'áá nizaad k'ehjí bee niłhodoonih dóó niká'adoolwołgo éí át'é.Ata' halne'é ła' bichį' hadeesdzih nínízingo éí 1-855-902-2583jį't'áá jíík'e béésh bee hodíílnih.

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## *This Booklet*

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

X21331 (12/01/2016)

Group Number: 10293334, 10295703, 04, 05, 06, 07, 13, 14, 15, 16, 17, 18, 19, 20

# 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;
- receive quality health care that is friendly and timely;
- have available and accessible Medically Necessary 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 St Louis 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.

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.

The health care Plan's benefit period is December 24, 2016 through December 31, 2017.

## 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.

### *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 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 Coinsurance and Deductible incurred for Covered Services in a 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. The Out-of-Pocket Limit does not include prescription drug expenses or amounts in excess of the Allowed Amount.

## 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.

## Allowed Amount

The discounted price the health care Plan will pay for a covered medical service or product. This price may be identified in a provider contract, by Medicare, by a nationwide provider reimbursement database or other method.

# 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.

## *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.

# Summary of Benefits

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

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **General Provisions** | | | |
| **Benefit Period** | The health care Plan's benefit period is 12/24/16 to 12/31/17 | | |
| **Deductible:** (per Benefit Period)<br>• Individual<br>• Family | <br>$250<br>$500 | <br>$500<br>$1,000 | <br>$750<br>$1,500 |
| **Deductible - Embedded**<br>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 person's covered Services even if the Deductible for the entire family has not been met. | | | |
| Amounts accumulated toward the Standard In-Network Providers Deductible also accumulate toward the Enhanced In-Network Providers Deductible. When the Standard In-Network Providers Deductible is satisfied, covered Services from both Standard In-Network Providers and Enhanced In-Network Providers will be paid at the covered percentage. | | | |
| Amounts accumulated toward the Enhanced In-Network Providers Deductible also accumulate toward the Standard In-Network Providers Deductible. | | | |
| **Coinsurance** - Based on the Allowed Amount | 90% after Deductible until Out-of-Pocket Limit is met; then 100% | 70% after Deductible until Out-of-Pocket Limit is met; then 100% | 50% after Deductible until Out-of-Pocket Limit is met; then 100% |
| **Out-of-Pocket Limit:**<br>• Prescription drug copays<br>▪ Individual<br>▪ Family | <br><br>$5,600<br>$11,200 | | |
| • All other eligible Services, excluding prescription drug copays<br>▪ Individual<br>▪ Family | <br>$750<br>$1,500 | <br>$2,500<br>$5,000 | <br>$5,500<br>$11,000 |
| Amounts accumulated toward the Standard In-Network Providers Out-of-Pocket Limit also accumulate toward the Enhanced In-Network Providers Out-of-Pocket Limit. When the Standard In-Network Providers Out-of-Pocket Limit is satisfied, covered Services from both Standard In-Network Providers and Enhanced In-Network Providers will be paid at 100% of the Allowed Amount. | | | |
| Amounts accumulated toward the Enhanced In-Network Providers Out-of-Pocket Limit also accumulate toward the Standard In-Network Providers Out-of-Pocket Limit. | | | |
| **Lifetime Maximum** (per member) | Unlimited | | |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **Office/Clinic/Urgent Care Visits** | | | |
| **Retail Health Clinic Visits** | | | |
| • office visit | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • lab Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • all other professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Physician** | | | |
| • office Visits | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • office and outpatient lab Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • office and outpatient diagnostic imaging Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • Medication Therapy Management (MTM) | 100% | 100% | NO COVERAGE |
| • Omada delivers a pre-diabetes prevention program. Members age 18 and older may participate in a curriculum (aka Prevent program) with digital tools to track improvement in diet, physical activity, and weight loss in the pre-diabetic population. | 100% | NO COVERAGE | NO COVERAGE |
| • all other professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **E-Visit** | 100% | 100% | 100% |
| **Urgent Care Center Visits** | | | |
| • professional Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • outpatient Facility (other than urgent care Facility provider lab and diagnostic imaging Services) | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • Facility lab Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • Facility diagnostic imaging Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **Preventive Care Services** | | | |
| **Adult** | | | |
| • Routine physical exams | 100%; Deductible does not apply | | 100% after Deductible |
| • Adult Immunizations | 100%; Deductible does not apply | | 100% after Deductible |
| • Diagnostic Services and procedures | 100%; Deductible does not apply | | 100% after Deductible |
| • Routine gynecological exams, including a PAP Test | 100%; Deductible does not apply | | 100% after Deductible |
| • Mammograms, annual routine and medically necessary | 100%; Deductible does not apply | | 100% after Deductible |
| • Colorectal Cancer Screening | 100%; Deductible does not apply | | 100% after Deductible |
| Services are limited to those on Blue Cross' Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply. | | | |
| **Pediatric** | | | |
| • Routine physical exams | 100%; Deductible does not apply | | 100% after Deductible |
| • Pediatric immunizations | 100%; Deductible does not apply | | 100% after Deductible |
| • Diagnostic Services and procedures | 100%; Deductible does not apply | | 100% after Deductible |
| Pediatric Preventive Care Services are limited to those on Blue Cross' Preventive Schedule. Gender, age and frequency limits may apply. | | | |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | | |
| **Inpatient Hospital Services** | | | |
| • Inpatient Hospital/Facility Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Outpatient Hospital Services** | | | |
| • Outpatient Hospital/Facility Services, except as noted below | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • laboratory Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • diagnostic imaging Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • free-standing ambulatory surgical center | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • urgent care Facility | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| **Medical/Surgical Expenses** (except office visits) | 100% after Deductible | 70% after Deductible | 50% after Deductible |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **Maternity** | | | |
| • prenatal Facility provider Services | 100%; Deductible does not apply | | 100% after Deductible |
| • prenatal professional Services | 100%; Deductible does not apply | | 100% after Deductible |
| • delivery Facility provider Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • delivery professional Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • postnatal professional Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| **Emergency Services** | | | |
| **Emergency Room Services** | | | |
| • Hospital/Facility charges | 100% after emergency room Facility provider $50 Copayment; Deductible does not apply | | |
| • professional charges | 100% | | |
| The emergency room Facility provider Copayment is waived if you are admitted within 24 hours. | | | |
| **Ambulance** | | | |
| • emergency medically necessary Services from the place of departure to the nearest medical Facility equipped to treat the condition | 90% after Enhanced In-Network providers Deductible. | | |
| • non-emergency medically necessary Services from the place of departure to the nearest medical Facility equipped to treat the condition | 90% after Enhanced In-Network providers Deductible. | | |
| **Therapy and Rehabilitation Services** | | | |
| **Occupational Therapy** | | | |
| • habilitative and rehabilitative office visits | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • habilitative and rehabilitative therapies | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Physical Medicine** | | | |
| • habilitative and rehabilitative office visits | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • habilitative and rehabilitative therapies | 90% after Deductible | 70% after Deductible | 50% after Deductible |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **Speech Therapy** | | | |
| • habilitative and rehabilitative office visits | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • habilitative and rehabilitative therapies | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Chiropractic Care** | | | |
| • Office visit/Evaluation/Lab | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • Spinal manipulations and other chiropractic Services including therapies | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Other Therapy Services** | | | |
| • **Professional Services**<br>▪ Cardiac Rehabilitation<br>▪ Chemotherapy<br>▪ Dialysis Treatment<br>▪ Infusion therapy<br>▪ Radiation therapy<br>▪ Respiratory therapy | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • **Hospital/Facility Outpatient**<br>▪ Cardiac Rehabilitation<br>▪ Chemotherapy<br>▪ Dialysis Treatment<br>▪ Infusion therapy<br>▪ Occupational therapy<br>▪ Physical medicine<br>▪ Radiation therapy<br>▪ Respiratory therapy<br>▪ Speech therapy | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Mental Health/Substance Abuse Services** | | | |
| **Mental Health Care Services** | | | |
| • Inpatient professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Inpatient Hospital/Residential Behavioral Health Treatment Facility Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Outpatient professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Lab and diagnostic imaging Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| • Outpatient Facility Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Substance Abuse Services** | | | |
| • Inpatient professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Inpatient Hospital/Residential Behavioral Health Treatment Facility Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Outpatient Professional Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Lab and diagnostic imaging Services | 100% after Deductible | 70% after Deductible | 50% after Deductible |
| • Outpatient Facility Services | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Other Services** | | | |
| **Allergy Extracts and Injections** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Durable Medical Equipment** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Insulin pumps, glucometers, and related equipment and devices | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Orthotics when prescribed by a physician | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Prosthetics | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Home Infusion and Suite Infusion Therapy Services** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Home Health Care** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Home Health Care limit: $25,000 per Calendar Year when you use an Out-of-Network Provider. The one (1) home health care visit following early maternity discharge does not apply to the $25,000 limit. | | | |
| **Hospice** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| **Assisted Fertilization** | For the level of coverage, see Physician, Inpatient Hospital Services and Outpatient Hospital Services | For the level of coverage, see Physician, Inpatient Hospital Services and Outpatient Hospital Services | For the level of coverage, see Physician, Inpatient Hospital Services and Outpatient Hospital Services |
| • Assisted Fertilization is subject to maximum limit of $10,000 per member medical Services and prescription drugs combined | | | |
| **Skilled Nursing Facility Care** | 90% after Deductible | 70% after Deductible | 50% after Deductible |
| • Skilled Nursing Facility Care is limited to an all network combined Limit of 180 days per Calendar Year | | | |

| Benefits | Enhanced In-Network Providers (Tier1) | Standard In-Network Providers (Tier2) | Out-of-Network Providers |
|---|---|---|---|
| **Transplant Services** | 100% of the Transplant Payment Allowance for the transplant Admission when you use a Blue Distinction Centers for Transplant (BDCT) Provider | NO COVERAGE. | NO COVERAGE. |

**Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all Services you receive during a  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<br>Up to 31-day supply | Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy<br>Up to 90-day supply | Nonparticipating Retail Pharmacy |
|---|---|---|---|
| **Pharmacy Network** | Participating Pharmacy | Participating: 90dayRx Retail and Mail Service Pharmacy | Nonparticipating Pharmacy |
| • **FlexRx Preferred Generic Drugs** | $10.00 Copayment | **90dayRx Participating Retail Pharmacy:**<br>$20.00 Copayment<br>**Mail Service Participating Pharmacy:**<br>$20.00 Copayment | $10.00 Copayment |
| • **FlexRx Preferred Brand Prescription Drugs** | $20.00 Copayment | **90dayRx Participating Retail Pharmacy:**<br>$40.00 Copayment<br>**Mail Service Participating Pharmacy:**<br>$40.00 Copayment | $20.00 Copayment |
| • **Non-Preferred Generic Prescription Drugs** | $10.00 Copayment | **90dayRx Participating Retail Pharmacy:**<br>$20.00 Copayment<br>**Mail Service Participating Pharmacy:**<br>$20.00 Copayment | $10.00 Copayment |
| • **Non-Preferred Brand Prescription Drugs** | $40.00 Copayment | **90dayRx Participating Retail Pharmacy:**<br>$80.00 Copayment<br>**Mail Service Participating Pharmacy:**<br>$80.00 Copayment | $40.00 Copayment |
| Retail Pharmacy Vaccine Program<br>• Certain eligible vaccines administered at a Participating retail pharmacy | $0.00 | NO COVERAGE | NO COVERAGE |
| • You are responsible for the payment differential when a Generic Drug is authorized by the Physician and you purchase a Brand Drug. Your payment is the price difference between the Brand Drug and Generic Drug in addition to the Brand Drug Copayment or Coinsurance amounts which may apply. | | | |
| • The Blue Cross 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 Blue Cross Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee. Your health care Plan includes coverage for both Preferred and non-preferred prescription drugs at the specific Copayment or coinsurance amounts listed above. | | | |

| **Prescription Drug Benefits** | **Retail Pharmacy**<br>Up to 31-day supply | **Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy**<br>Up to 90-day supply | **Nonparticipating Retail Pharmacy** |
|---|---|---|---|
| **Pharmacy Network** | Participating Pharmacy | Participating: 90dayRx Retail and Mail Service Pharmacy | Nonparticipating Pharmacy |
| **Preventive Medications** | | | |
| • **Preventive Covered prescription drugs** | 100%<br>Deductibles, Coinsurance and/or Copayments do not apply | 100%<br>Deductibles, Coinsurance and/or Copayments do not apply | 100%<br>Deductibles, Coinsurance and/or Copayments do not apply |
| This includes 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 emergency care Services.

## 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 $350 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 you 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
- Skilled Nursing Services – Intermittent Hours of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing Services also known as Skilled Nursing Care, Extended Hours
- 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 or 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.

### *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;
- diagnostic Services; or
- therapy and rehabilitation Services.

## *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;
- 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 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:

### 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 must be started within six (6) months of the injury

### 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*

### 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

An E-visit includes a member initiated, limited online evaluation and management health care Service or a real-time office visit with a Specialist at a remote location, conducted via interactive audio and streaming video telecommunications. Benefits are provided for a Specialist virtual visit which is subsequent to your initial visit with your treating Specialist for the same condition. The provider-based location from which you communicate with the Specialist is referred to as the "originating site".

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.

### 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.

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 otherwise covered under this health care Plan.

Coverage is provided for Treatment of emotionally disabled Dependent children in a licensed Residential Behavioral Health Treatment Facility.

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.

### 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.

## *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*

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 Claim 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 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.

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 breastfeeding support and counseling.

### 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: one (1) per Calendar Year.

### Surveillance tests for ovarian cancer

- Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam): one (1) per Calendar Year.

## *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.

You must be admitted within 30 days of a prior hospital stay of at least Three (3) consecutive days for the same illness.

### 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

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 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 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 natural teeth if the Treatment begins within 6 months of either the date of the injury or first date of coverage.
- 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
- Infusion therapy when performed by a Facility provider and for self-administration if the components are furnished and billed by a Facility provider
- 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):

The following Medically Necessary 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.

# Covered Services - Prescription Drug Program

Prescription Drugs are covered when you purchase them through the pharmacy network applicable to your health care Plan and out-of-network pharmacies. For convenience and choice, network pharmacies include both major chains and independent stores.

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 in a 31 day supply. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.

**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.

To help contain costs, if a Generic Drug is available, you will be given the Generic Drug. As you probably know, Generic Drugs have the same chemical composition and therapeutic effects as Brand Drugs and must meet the same FDA requirements.

Should you purchase a Brand Drug when a Generic Drug is available and authorized by your doctor, you must pay the price difference between the Brand Drug and Generic Drug prices in addition to the applicable Copayment or Coinsurance amount.

## 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;
- Prescription Drugs listed in your health care Plan's prescription drug Preferred Drug List; including compounded medications, consisting of the mixture of at least two or more FDA-approved Prescription Drugs/medications. (Refer to "Terms You Should Know");
- Antipsychotic Prescription Drugs and preferred Prescription Drugs prescribed to treat emotional disturbance or Mental Illness will be covered on the same basis (applicable level) as all other eligible Prescription Drugs.
- 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 preventive drugs with a prescription (such as FDA-approved Tobacco Cessation Drugs and Products, aspirin, folic acid, vitamin D, iron 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 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 specified Preferred 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, 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).
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- 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 unless you are a participant in Stop-Smoking Support where over-the-counter Tobacco Cessation Drugs and Products will be provided for you.
- If you choose 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. Certain Brand Drugs are not covered when a Generic Drug is available. For a list of Brand Drugs not covered when a Generic Drug is available, visit www.bluecrossmnonline.com, or contact Member Service at the telephone number listed on the back of your member ID card.
- 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.

## 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. 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.
- Your prescription drug program follows a select drug list which is referred to as a "Preferred Drug List.
- Your health care Plan includes coverage for both preferred Prescription Drugs and non-preferred Prescription Drugs.

- To receive a copy of the Preferred Drug List, call Member Service at the telephone number on the back of your member ID card. You can also look up the Preferred Drug List at www.bluecrossmnonline.com.
- When identical chemical entities are from different manufacturers or distributors, the Claims Administrator's Coverage Committee may determine that only one (1) of those drug products is covered and the other equivalent products are not covered.
- Self-administered injectable and oral prescription drugs for Assisted Fertilization 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.
- These listings are subject to periodic review and modification by the Claims Administrator or a designated committee of Physicians and pharmacists.

**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:

- 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.
- 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.
- Court ordered Services or confinements by a court or law enforcement officer that are not medically necessary, except as specified under Minnesota law.
- Custodial Care, domiciliary care, residential care, protective and supportive care including educational Services, rest cures and convalescent care.
- Services rendered prior to your effective date of coverage.
- Services which are Investigative in nature, except for certain routine care for approved clinical trials.
- 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).
- 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.
- 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 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.
- Cosmetic surgery Services related to sex transformation surgery are not covered.
- Services for hearing aid devices and tinnitus maskers for adults age 19 and older, except as provided herein.
- 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.
- Charges for inpatient Admissions which are primarily for diagnostic studies.
- Charges for inpatient Admissions which are primarily for physical therapy Services.
- Services for the Treatment of learning disabilities.
- Services for or related to marriage/couples counseling.
- Services for or related to oral surgery and anesthesia for the removal of impacted teeth, removal of a tooth root without removal of the whole tooth, and root canal therapy.

- Treatments, Services, or supplies which are not based on the definition of “Medically Necessary and Appropriate” in the “Terms You Should Know” section.
- 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.
- Charges for methadone hydrochloride Treatment for which no additional functional progress is expected to occur.
- 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.
- Charges for the covered patient’s failure to keep a scheduled visit.
- Charges billed by your Provider for the completion of a Claim form.
- Charges for any other medical or dental Service or Treatment or prescription drug, except as provided herein.
- 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.
- Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
- Oral surgery procedures, except as provided herein.
- 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.
- Services which are not prescribed by or performed by or upon the direction of a professional provider.
- Services rendered by other than ancillary Providers, Facility Providers or professional Providers.
- 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.
- Services rendered by a Provider who is a member of your Immediate Family.
- Services performed by a professional Provider enrolled in an education or training program when such Services are related to the education or training program.
- For Respite Care, except as provided herein.
- 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.
- Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
- Charges for or related to reversal of sterilization.
- Charges incurred after the date of termination of your coverage, except as provided herein.
- 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.
- Charges for transportation other than local ambulance to the nearest medical Facility provider equipped to treat the condition, except as provided herein.

- 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.
- Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and appropriate.
- 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.
- Services that are provided without charge, including Services of the clergy
- 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
- Services for or related to therapeutic acupuncture, except for the Treatment of chronic pain; and, nausea associated with surgery, chemotherapy, or pregnancy.
- Services for Dependents if you have Group Member-only coverage.
- Services that are not within the scope of licensure or certification of a provider.
- Services that are prohibited by law or regulation.
- Charges for furnishing medical records or reports and associated delivery charges.
- Services for or related to transportation, other than local ambulance service, to the nearest medical Facility equipped to treat the Illness or injury, except as specified in the "Summary of Benefits."
- Travel Transportation, or living expenses, whether or not recommended by a Physician, except as specified in the "Summary of Benefits."
- Services for or related for Mental Illness not listed in the most recent addition of the ICD and DSM.
- Services or confinements ordered by a court or law enforcement officer that are not Medically Necessary.
- Charges for evaluations that are not performed for the purpose of diagnosing of 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.
- Services for or related to room and board for foster care, group homes, shelter care and lodging programs, Halfway House Services and Skills Training.
- Services for or related to therapeutic support of foster care.
- Services for or related to Substance Abuse or addictions that are not listed in the most recent edition of the ICD and DSM.
- Services for or related to therapeutic massage.
- Charges for personal comfort items such as telephone, television.
- Charges for communication Services provided on an outpatient basis or in the home.
- Services for or related to experimental Infertility Treatment procedures, surrogacy Services, or cryopreservation of eggs or sperm.
- Donor ova or sperm.
- 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.
- Scalp/cranial hair prostheses (wig) for any diagnosis other than alopecia areata.
- Charges for blood pressure monitoring devices.

- Charges for communication devices, provider initiated e-mails and internet or similar network communications.
- Services related to vocational rehabilitation.
- Services and fees for or related to health clubs and spas.
- Maintenance Services.
- Services for or related to recreational and educational therapy.
- Services and supplies for weight loss programs.
- Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
- Services for or related to gene therapy as a Treatment for inherited or acquired disorders.
- Charges for growth hormone replacement therapy, except for Services that meet medical necessity criteria.
- Charges for autopsies.
- Services for or related to transcranial magnetic stimulation therapy.
- Over the counter drugs, e.g. vitamins or dietary supplements, except as specified in this Booklet.
- Services, supplies, drugs and Aftercare for or related to artificial or nonhuman organ implants.
- Services for or related to fetal tissue transplantation.
- Charges for routine dental care, except as specified in this Booklet.
- Charges for Foot Orthoses, except as specified in this Booklet.
- Services for or related to Skilled Nursing Care - Extended Hours, also referred to as private duty nursing care, except as required by Minnesota Law.

***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:***

- Charges for Prescription Drugs dispensed for Treatment of an Illness or an injury for which the group is required by law to furnish Hospital care in whole or in part–including, but not limited to state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- Charges for Prescription Drugs to which you are entitled, with or without charge, under a Plan or program of any government or governmental body.
- Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- Charges for administration of self-administered Prescription Drugs and/or injectable insulin, whether by a Physician or other person.
- Charges for prescription contraceptive drugs and supplies.
- Any charges by any pharmacy Provider or pharmacist, except as provided herein.
- Charges for any drug or medication, except as provided herein.
- Charges for Investigative or non-(FDA) approved drugs, except as specified by law.
- Charges for drugs and supplies that are not Medically Necessary and Appropriate or otherwise excluded herein.
- Any amounts above the Deductible, Coinsurance, Copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
- Charges for any prescription for more than the retail days supply or 90dayRx days supply as outlined in the "Summary of Benefits" section.

- Charges for any drug or medication which does not meet the definition of Covered Maintenance Prescription Drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Prescription Drugs section for more information.
- Charges for over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Prescription Drugs section for more information.
- Charges for hair growth stimulants.
- Charges for food supplements.
- Charges for blood products, except as provided herein.
- Charges for any drugs prescribed for cosmetic purposes only.
- Charges for any drug which has been disallowed under the Prescription Drug Management section of this booklet.
- Charges for any drugs which are Investigative.
- Charges for any drugs and supplies which can be purchased without a prescription order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein.
- Charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
- Charges for any selected diagnostic agents.

# 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.

You may be responsible for paying any difference between the provider’s actual charge and the Claims Administrator’s payment.

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *unless it is an emergency*. **That’s why it is critical that you check to see that your provider is in the network before you receive care.**

## 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 Card PPO 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 BlueCard PPO network, these Services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or Illness occurs, you should seek Treatment 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 BlueCard PPO network. If the Treatment results in an admission, the local BlueCard PPO 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 BlueCard PPO 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 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 the Claims Administrator 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 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. 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, such as Hospital-based Providers (e.g., anesthesiologists) who 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 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 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, you are entitled to the following Services:

1. 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 Treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the Physician and member. Coverage is provided on the same basis as any other Illness.

## 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 remain subject to any requirements outlined in Blue Cross' medical policy and/or federal law.

# Inter-Plan Programs

### *Out-of-Area Services*

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care Services outside of Claims Administrator's Service Area, the claims for these Services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's' Service Area, you will obtain care from Health Care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Nonparticipating Providers. The Claims Administrator's payment practices in both instances are described below.

***Inter-Plan Programs Eligibility – Claim Types***

All Claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all Dental Care benefits (unless 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 access covered health care Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling the Claims Administrator's contractual obligations with you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you access 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 actual 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, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your Claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered health care Services as required by law.

***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.

***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 insured 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 Claims Administrator will pay based on the definition of "Allowed Amount" as set forth in the "Terms You Should Know" section of this booklet. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered Services as set forth in this paragraph.

***BlueCard Worldwide® Program***

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 the BlueCard Worldwide® Program when accessing covered health care Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the BlueCard Worldwide Program 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 BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide International Claim form and send the Claim form with the provider's itemized bill(s) to the BlueCard Worldwide 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 BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your Claim, submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

## 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.**

## *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.

## *Eligible Providers*

Eligible Network Providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of Specialists.

### Facility Providers:

- Hospital
- Psychiatric Hospital
- Rehabilitation Hospital
- Ambulatory surgical Facility
- Birthing Facility
- Day/night psychiatric Facility
- Freestanding dialysis Facility
- Freestanding nuclear magnetic resonance Facility/magnetic resonance imaging Facility
- Home health care agency
- Outpatient Substance Abuse Treatment Facility
- Outpatient physical rehabilitation Facility
- Outpatient psychiatric Facility
- Pharmacy provider
- Skilled Nursing Facility
- State-owned psychiatric Hospital
- Substance abuse Treatment Facility

### Professional Providers:

- Audiologist
- Behavior specialist
- Certified registered nurse
- Chiropractor
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist

### Ancillary Providers:

- Ambulance Service
- Clinical laboratory
- Home infusion and suite infusion therapy provider
- Suppliers
- Durable Medical Equipment

## *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 Pharmacy 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.

# Medical Management

The Claims Administrator reviews Services to verify that they are medically necessary 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.

For **inpatient Hospital/Facility Services**, all Network Providers and Out-of-Network Participating Providers are required to obtain Prior Authorization for you. You are responsible for obtaining Prior Authorization when receiving **inpatient Hospital/Facility Services** from Nonparticipating Providers.

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.

**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. If it is found, at the point the Claim from a Network Provider outside Minnesota or Nonparticipating Provider is processed, that Services were not medically necessary, 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.

For Prior Authorization of urgently needed care, please refer to the "Expedited Review Determination" process in the "Appeal Process" section.

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 (choose the "Providers" tab in the lower left corner, then the "Medical Policy" tab under "Tools and Resources") or call Member Service.

**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 you are going to receive nonemergency care from Nonparticipating Providers, 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. **You are also required to obtain Prior Authorization for the Services related to the inpatient Admission. Please refer to "Prior Authorization" in this section. Minnesota Network Providers who do not obtain preadmission notification for you are responsible for the charges, if the Admission is found to be not medically necessary. If it is found, at the point the Claim from a Network Provider outside Minnesota or Nonparticipating Provider is processed, that Services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following Admissions/facilities:

1. Hospital acute care Admissions;
2. Residential behavioral health Treatment facilities; and,
3. Mental health and Substance Abuse Admissions.

**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 you are going to receive nonemergency care from Nonparticipating Providers, 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. **You are also required to obtain Prior Authorization for the Services related to the inpatient Admission. Please refer to "Prior Authorization" in this section. Minnesota Network Providers who do not obtain preadmission certification for you are responsible for the charges if the Admission is found to be not medically necessary. If it is found, at the point the Claim from a Network Provider outside Minnesota or a Nonparticipating Provider is processed, that Services were not medically necessary, you are liable for all of 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, you are required to provide emergency admission notification to the Claims Administrator as soon as reasonably possible after an Admission for pregnancy, Medical Emergency, or injury that occurred within 48 hours of the Admission.

All 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.

If you receive care from Nonparticipating Providers, you are required to provide emergency Admission notification to the Claims Administrator within 48 hours of the Admission or as soon as reasonably possible after Admission for pregnancy, Medical Emergency, or injury. 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. **If this notification is not provided and it is found, at the point the Claim is processed, that Services were not medically necessary, 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 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 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's Medical Policy Committee develops medical policies that determine whether new or existing medical Treatment should be Covered Services. The Medical Policy Committee is made up of independent community Physicians who represent a variety of medical specialties. The Medical Policy Committee's goal is to find the right balance between making improved Treatments available and guarding against unsafe or unproven approaches. The Medical Policy Committee carefully examines the scientific evidence and outcomes for each Treatment being considered. From time-to-time new medical policies may be created or existing medical policies may change. Covered Services will be determined in accordance with the Claims Administrator's policies in effect at the time Treatment is rendered. Prior Authorization may also be required. The Claims Administrator's medical policies can be found at the member website and are hereby incorporated by reference.

# 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***

All full time and part time employees as defined by St. Lousi County are eligible for single or family coverage.

The waiting period is one (1) full calendar month. With timely application, coverage is effective the first of the month following completion of the waiting period.

The surviving spouse and/or dependents of an employee who are not enrolled in the Plan at the time of death of the employee are eligible. The spouse and/or dependents have 60 days from the death of the employee to make application to the Plan Administrator for coverage and fulfill any requirements. The surviving spouse and/or dependents effective date of coverage is the first of the month following the day the Plan Administrator receives the application.

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:

- Spouse to whom you are legally married.

## *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 continuously from birth and are financially dependent primarily upon you
- 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*

If the Plan Administrator receives your application within 30 days after you become eligible, coverage for you and your eligible Dependents starts the first of the month following the date of eligibility.

# Adding New Dependents

### *Adding a Spouse and/or Stepchildren*

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 the Plan Administrator receives the application within 90 days of the date of birth, adoption or placement coverage starts on the date of birth, adoption or placement.

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.

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 (60 days for loss of Medicaid or CHIP)** of the triggering event. 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 90 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):<br>• Loss of eligibility for employer-sponsored coverage<br>• Plan no longer offers benefits<br>• Termination of all employer contributions<br>• Termination of employment or reduction in hours that results in a loss of coverage<br>• Legal separation or divorce<br>• Loss of Dependent child status<br>• Death of employee<br>• Move outside HMO or ACO Service Area<br>• Exceeding the plan's Lifetime Maximum<br>• Employer bankruptcy<br>• COBRA exhaustion<br>• 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. |
| Gaining a Dependent due to birth, adoption, placement for adoption, or placement for foster care. |
| An individual loses eligibility for Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP). |
| Child support order or other Court order to provide coverage. |
| Employee moves from a part-time to a full-time position or returns from an unpaid leave of absence |

# 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.

Benefits Advisor

100 N 5th Ave West, Room 1

Duluth, MN 55802

218-725-5056

# 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 request that coverage be terminated.
   d. you retire.

# Extension of Benefits

If you or your Dependent is confined as an inpatient on the date coverage ends due to the replacement of the Claims Administrator, the health 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 <u>if you lose coverage</u> 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).

If you are the ***spouse/ex-spouse*** of a covered ***Employee***, you have the right to elect continuation coverage <u>if you lose coverage</u> 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.

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.

***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 health care Plan'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***. 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 the Plan Administrator provides you or your family member with 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.

***How to Elect***

Contact the Employer to determine how to elect continuation coverage. Human Resources: 218-726-2422.

### *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 health care Plan 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 Employer 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 of the ***Employee's*** death, divorce, legal separation, the ***Employee*** became enrolled in Medicare or because of a loss of Dependent status under the health care Plan, then the maximum coverage period (for spouse and Dependent child) is three (3) years from the date of the qualifying event.

### *Continuation Premiums*

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. In the event of a Dependent's disability, the premiums for continuation for the Employee and Dependents can be up to 150 percent of the group rate for months 19-29 if the disabled Dependent is covered. All premiums are paid directly to the Employer.

### *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 you or 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 health care 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 maximum coverage period (i.e., death of the ***Employee,*** divorce, legal separation, the ***Employee*** becoming enrolled in Medicare or a Dependent child losing Dependent status). 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.

- ***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 health care Plan), 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 health care Plan, 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.
- After electing continuation, you or your Dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your Dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- 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 health care Plan, 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.

### *Special Second Election Period*

Special continuation rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect continuation coverage for themselves and certain family members (if they did not already elect continuation coverage) during a special second election period. This election period is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within six (6) months of losing coverage. Please contact the Plan Administrator for additional information.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

### *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/Extension | Who May Continue | Maximum Continuation Period |
|---|---|---|
| Employment ends (for reasons other than gross misconduct)<br>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:<br>1. 18 months, or<br>2. Enrollment Date in other group coverage. |
| Divorce or legal separation | Ex-spouse/spouse and any Dependent children that lose coverage | Earlier of:<br>1. Enrollment Date in other group coverage, or<br>2. Date coverage would otherwise end. |
| Death of Employee | Surviving spouse and Dependent children | Earlier of:<br>1. Enrollment Date in other group coverage, or<br>2. Date coverage would otherwise end if the Employee had lived. |
| Dependent child loses eligibility | Dependent child | Earliest of:<br>1. 36 months, or<br>2. Enrollment Date in other group coverage, or<br>3. Date coverage would otherwise end. |
| Dependents lose eligibility due to the Employee's enrollment in Medicare | All Dependents | Earliest of:<br>1. 36 months, or<br>2. Enrollment Date in other group coverage, or<br>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. |
| **Extensions to 18-month maximum continuation period:**<br>Disability, as determined by the Social Security Administration, of Employee or Dependent(s) | Disabled individual and all other covered family members | Earliest of:<br>1. 29 months after the Employee leaves employment, or<br>2. Date Total Disability ends, or<br>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).

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

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

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

## *Order of Benefits Rules*

1. General: When a claim is filed under This Plan and another plan, This Plan is a Secondary Plan and determines benefits after the other plan, unless:

   a. the other plan has rules coordinating its benefits with This Plan's benefits; and

   b. the other plan's rules and This Plan's rules, in part 2. below, require This Plan to determine benefits before the other plan.

2. Rules: This Plan determines benefits using the first of the following rules that applies:

   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.

   b. Nondependent/Dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a Dependent) determines its benefits before the plan that covers the person as a Dependent.

   c. Dependent child of parents not separated or divorced: When This Plan and another plan cover the same child as a Dependent of different persons, called "parents":

      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

   d. Dependent child of parents divorced or separated: 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:

   When the sum of:

   a. the benefits payable for allowable medical expenses under this health care plan, without applying coordination of benefits, and,

b. the benefits payable for allowable medical expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceed those allowable medical expenses in a claim determination period. In that case, the benefits of this health care plan are reduced so that benefits payable under all plans do not exceed allowable medical expenses.

When medical 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

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

***The Health Care Plan’s Right of Subrogation***

If you or your Dependents receive benefits under this Plan arising out of an Illness or injury for which a responsible party is or may be liable, this Plan shall be subrogated to your Claims and/or your Dependents’ Claims against the responsible party.

***Obligation to Reimburse the Health Care Plan***

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

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

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

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

**Complying with these obligations to reimburse the health care Plan is a condition of your continued coverage and the continued coverage of your Dependents.**

***Duty to Cooperate***

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

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

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

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

You have a continuing obligation to notify the Claims Administrator of information about your efforts or your Dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your Dependents must complete and sign all forms and papers, including a Reimbursement Agreement,** as required by the health care Plan and provide any other information required by the health care Plan. A violation of the reimbursement agreement is considered a violation of the terms of the health care Plan.

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

***Attorney's Fees and Other Expenses You Incur***

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

The Plan Administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the Claims Administrator.

***What May Happen to Your Future Benefits***

If you or your Dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the health care Plan, the health care Plan in the exercise of its sole and complete discretion, may determine that you, your Dependents, your attorneys or other representatives have failed to cooperate with the health care Plan's subrogation and reimbursement efforts. If the health care Plan determines that you have failed to cooperate the health care Plan may decline to pay for any additional care or Treatment for you or your Dependent(s) until the health care Plan is reimbursed in accordance with the health care

Plan terms or until the additional care or Treatment exceeds any amounts that you or your Dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to Treatment related to the injury, but will apply to all benefits otherwise payable under the health care Plan for you and your Dependents.

***Interpretation***

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

# 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.

# Claims Procedures

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

## Types of Claims

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

### *Pre-Service Claim*

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

### *Urgent Care Claim*

An “Urgent Care Claim” is a special type of Pre-Service Claim. An “Urgent Care Claim” is any Pre-Service Claim for medical care or Treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the Claim. The Claims Administrator will determine whether a Pre-Service Claim involves urgent care, provided that, if a Physician with knowledge of the claimant’s medical condition determines that a Claim involves urgent care, the Claim will be treated as an Urgent Care Claim.

**IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the Claims Administrator for prior approval. The claimant should obtain such care without delay.**

### *Concurrent Care Claim*

A “Concurrent Care Claim" arises when the Claims Administrator has approved an ongoing course of Treatment to be provided over a period of time or number of Treatments, and either (a) the Claims Administrator determines that the course of Treatment should be reduced or terminated, or (b) the claimant requests extension of the course of Treatment beyond that which the Claims Administrator has approved. If the Plan does not require a claimant to obtain approval of a medical Service prior to getting Treatment, then there is no need to contact the Claims Administrator to request an extension of a course of Treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of Treatment, and files the Claim as a Post-Service Claim.

### *Post-Service Claim*

A “Post-Service Claim” is any request for a Plan benefit that is not a Pre-Service Claim or an Urgent Care Claim.

### *Change in Claim Type*

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

# Filing Claims

Except for Urgent Care Claims, discussed below, a Claim is made when a claimant (or authorized representative) submits a request for Plan benefits to the Claims Administrator. A claimant is not responsible for submitting claims for Services received from Network or Out-of-Network Participating Providers. These providers will submit claims directly to the local Blue Cross and Blue Shield Plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives Services from Nonparticipating Providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the Claims Administrator. The necessary forms may be obtained by contacting the Claims Administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

### *Urgent Care Claims*

An Urgent Care Claim may be submitted to the Claims Administrator by calling the telephone number located on the back of your ID card.

### *Pre-Service Claims*

A Pre-Service Claim (including a Concurrent Care Claim that is also a Pre-Service Claim) is considered filed when the request for approval of Treatment or Services is made and received by the Claims Administrator.

### *Post-Service Claims*

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

### *Incorrectly Filed Claims*

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

# Timeframes for Deciding Claims

### *Urgent Care Claims*

The Claims Administrator will decide an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the Claim.

### *Pre-Service Claims*

The Claims Administrator will decide a Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.

### *Concurrent Care Extension Request*

If a Claim is a request to extend a concurrent care decision involving urgent care and if the Claim is made at least 24 hours prior to the end of the approved period of time or number of Treatments, the Claims Administrator will decide the Claim within 24 hours after receipt of the Claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.

### *Concurrent Care Reduction or Early Termination*

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

### *Post-Service Claims*

The Claims Administrator will decide a Post-Service Claim within a reasonable time, but no later than 30 days after receipt of the Claim.

### *Extensions of Time*

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

## Incomplete Claims

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

If a Pre-Service or Post-Service Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible. The notice will explain that the Claim is incomplete and describe the information needed to complete the Claim. The timeframe for deciding the Claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the Claims Administrator. The Claims Administrator will decide the Claim following receipt of the requested information and provide the claimant with written notice of the decision.

## Notification of Initial Benefit Decision

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a Claim. A decision on a Claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Claims Administrator will provide the claimant written notice of the decision on a Pre-Service or Urgent Care Claim whether the decision is adverse or not. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

## Appeals of Adverse Benefit Determinations

### *Appeal Procedures*

If you are covered under a plan offered by a state health plan, a city, county, school district, or Service Cooperative, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination. The Claims Administrator will follow these procedures when deciding an appeal:

1. A claimant must file an appeal with the Claims Administrator within 180 days following receipt of a notice of an adverse benefit determination;
2. A claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits;
3. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual;
4. The Claims Administrator will give no deference to the initial benefit decision;

5. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit decision;
6. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
7. The Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice; and
8. The Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's Claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Claims Administrator.

### *Filing Appeals*

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

### *Urgent Care Appeals*

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

## Timeframes for Deciding Appeals

### *Urgent Care Claims*

The Claims Administrator will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

### *Pre-Service Claims*

The Claims Administrator will decide the appeal of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

### *Post-Service Claims*

The Claims Administrator will decide the appeal of a Post-Service Claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

### *Concurrent Care Claims*

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of Treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.

## Notification of Appeal Decision

The Claims Administrator will provide the claimant with written notice of the appeal decision. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. The decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced**.

# Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-Service or Post-Service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-Service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

# Additional Provisions

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-Service or Post-Service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-Service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

### *Authorized Representative*

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

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the Claims Administrator.

### *Claims Payment*

When a claimant uses Network or Out-of-Network Participating Providers, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for Covered Services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Claims Administrator.

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

### *No Third Party Beneficiaries*

The Plan benefits described in this Summary Plan Description 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 Summary Plan Description 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. The Claims Administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant’s failure to provide authorization or requested information may result in denial of the claimant’s Claim.

### *Right of Examination*

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any Claim. The Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant's failure to comply with this request may result in denial of the claimant's Claim.

### *Filing Appeals*

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

### *Urgent Care Appeals*

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

## Timeframes for Deciding Appeals

### *Urgent Care Claims*

The Claims Administrator will decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

### *Pre-Service Claims*

The Claims Administrator will decide the appeal of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

### *Post-Service Claims*

The Claims Administrator will decide the appeal of a Post-Service Claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

### *Concurrent Care Claims*

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of Treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.

## Notification of Appeal Decision

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

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

# Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-Service or Post-Service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-Service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

# External Review

***Standard External Review***

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

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

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

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

   The IRO will review all of the information and documents timely received and is not bound by the Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

   a. your medical records;
   b. the attending health care professional's recommendation;
   c. reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you, or your treating provider;
   d. the terms of the Plan;
   e. evidence-based practice guidelines;
   f. any applicable clinical review criteria developed and used by the Claims Administrator; and
   g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

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

### *Expedited External Review*

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

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

# Additional Provisions

A voluntary appeal may be available to a claimant receiving an adverse decision on a Pre-Service or Post-Service Claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse Pre-Service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Claims Administrator.

### *Authorized Representative*

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

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the Claims Administrator.

### *Claims Payment*

When a claimant uses Network or Out-of-Network Participating Providers, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for Covered Services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Claims Administrator.

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

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***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. The Claims Administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's Claim.

***Right of Examination***

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any Claim. The Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant's failure to comply with this request may result in denial of the claimant's Claim.

# 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:

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 "Benefit Chart." 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 that 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 edition 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 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 covered Maintenance Prescription Drug, unless otherwise expressly excluded.

**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.

**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 part of specialized therapy for the member's condition.

**Medical Emergency -** Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the 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  Network.
- When you receive Services within the Claims Administrator's Service Area, the designated Network for professional providers and Facility providers is the  Network.
- When you receive Services outside Minnesota, the designated participating Network for professional providers and Facility providers is the local PPO 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.

**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. Your health care Plan includes coverage for both Preferred and non-preferred Prescription Drugs at the specific cost-sharing amounts listed in the "Summary of Benefits" section.

**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 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. 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 edition 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 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.

**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.