BlueCross BlueShield Minnesota

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COMPREHENSIVE MAJOR MEDICAL GROUP BOOKLET

THIS COVERAGE IS A MINNESOTA NONQUALIFIED PLAN

For Employees of:
Waconia School District ISD 110

PLEASE READ YOUR BOOKLET CAREFULLY

Language Access Services

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

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

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

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

နမ့်ကတိၤကသိကျိာ်ဒီး, တ၊်ကဟ့ာ်နၤကျိာ်တ၊်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိ်, ကိး 711 တက့၊်.

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

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

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

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

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

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

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

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

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

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

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

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

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This Booklet

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

Blue Cross and Blue Shield of Minnesota Member Rights and Responsibilities

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

- be treated with respect, dignity and privacy;
- have available and accessible Medically Necessary and Appropriate covered Services, including emergency Services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding Treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for Treatment;
- participate with your Health Care Provider in decisions about your Treatment;
- give your Health Care Provider a health care directive or a living will (a list of instructions about health Treatments to be carried out in the event of incapacity);
- refuse Treatment;
- privacy of medical and financial records maintained by Blue Cross and its Health Care Providers in accordance with existing law;
- receive information about Blue Cross, its Services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at Blue Cross or at the clinic that you can contact with any concerns about Services;
- file a complaint or appeal with Blue Cross and receive a prompt and fair review. In addition, you may file your appeal with the Minnesota Department of Commerce; and,
- initiate a legal proceeding when experiencing a problem with Blue Cross 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 Blue Cross 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 Blue Cross health care Plan. We encourage you 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 us before the effective date. For purposes of this booklet, "you" or "your" refers to the Group Member named on the identification (ID) card and other covered Dependents. Group Member is the person for whom the Group Contractholder has provided coverage. Dependent is a covered Dependent of the Group Member. The Group Contractholder has contracted with us to provide coverage for its Group Members and their Dependents. "We," "us," and "our" refer to Blue Cross. Other 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.

Blue Cross is the insurer and the Claims Administrator. This health care Plan is a fully-insured medical Plan. Coverage is subject to all terms and conditions of this booklet, including Medically Necessary and Appropriateness.

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

A copy of our privacy procedures is available on our website at www.bluecrossmnonline.com or by calling 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 Blue Cross. A charge shall be considered incurred on the date you receive the Service or Supply for which the charge is made.

Your group's benefit period is based on a Plan year. The Plan year is a consecutive 12-month period beginning on the renewal date.

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 Blue Cross 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 Plan 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 incurred for Covered Services in a Plan year. When the specified dollar amount is attained, Blue Cross begins to pay 100% of the Allowed Amount for all covered expenses. See the "Summary of Benefits" section for the out-of-pocket limit.

Maximum

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

Prescription Drug Cost-Sharing Provisions

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

Copayment

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

Coinsurance

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

Deductible

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

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of Coinsurance incurred for covered medications in a Plan year. When the specified dollar amount is attained, Blue Cross begins to pay 100% of the Allowed Amount for all covered expenses. See your "Summary of Benefits" section for the out-of-pocket limit.

Summary of Benefits

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

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

• Network Participating Providers – Medical Services	
▪ In Minnesota	Aware Network Providers
▪ Outside Minnesota	Blue Card Traditional Network Providers
• Pharmacy Network Participating Provider	Select Pharmacy Network

Benefits	**Network**	**Out-of-Network**
General Provisions		
Benefit Period	Plan year	
Your group's benefit period is based on a Plan year. The Plan year is a consecutive 12-month period beginning on the renewal date.		
Deductible • Individual • Family	 $1,750 $3,500	
Deductible carryover applies. (The amount applied toward your Deductible, under this health care Plan, during the last three (3) months of the Plan year that is applied toward your Deductible, under this health care Plan, for the next Plan year. This amount will not be applied toward the out-of-pocket limit for the next Plan year.)		
Plan Payment Level - Based on the Allowed Amount	Generally, 80% after Deductible until out-of-pocket limit is met; then 100%	Generally, 80% after Deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits – eligible medical Services including Pharmacy • Individual • Family	 $3,000 $6,000	
Lifetime Maximum (per member) • Assisted Fertilization ▪ All Services combined (medical and Prescription Drugs) • Total benefits paid to all other providers combined	 $10,000 Unlimited	

Benefits	Network	Out-of-Network
Office/Clinic/Urgent Care Visits		
Retail Health Clinic Visits		
• office visit	80% after Deductible	80% after Deductible
• lab Services	80% after Deductible	80% after Deductible
• all other professional Services	80% after Deductible	80% after Deductible
Physician		
• office visits	80% after Deductible	80% after Deductible
• office and outpatient lab Services	80% after Deductible	80% after Deductible
• office and outpatient diagnostic imaging Services	80% after Deductible	80% after Deductible
• Allergy Services as follows:		
▪ allergy testing	80% after Deductible	80% after Deductible
▪ allergy serum	80% after Deductible	80% after Deductible
▪ allergy injections	80% after Deductible	80% after Deductible
• E-Visit, telephone consultations	80% after Deductible	80% after Deductible
• All other professional Services	80% after Deductible	80% after Deductible
Specialist		
• office visits	80% after Deductible	80% after Deductible
• office and outpatient lab Services	80% after Deductible	80% after Deductible
• office and outpatient diagnostic imaging Services	80% after Deductible	80% after Deductible
• Allergy Services as follows:		
▪ allergy testing	80% after Deductible	80% after Deductible
▪ allergy serum	80% after Deductible	80% after Deductible
▪ allergy injections	80% after Deductible	80% after Deductible
• E-Visit, telephone consultations	80% after Deductible	80% after Deductible
• All other professional Services	80% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
Urgent Care Center Visits		
• professional Urgent Care Services ▪ professional office visit for Urgent Care	80% after Deductible	80% after Deductible
▪ professional lab Services for Urgent Care	80% after Deductible	80% after Deductible
▪ professional diagnostic imaging Services for Urgent Care	80% after Deductible	80% after Deductible
▪ all other professional services for Urgent Care	80% after Deductible	80% after Deductible
• Facility Urgent Care Services (other than urgent care Facility provider lab and diagnostic imaging Services)	80% after Deductible	80% after Deductible
▪ Facility lab Services for Urgent Care	80% after Deductible	80% after Deductible
▪ Facility diagnostic imaging Services for Urgent Care	80% after Deductible	80% after Deductible
Preventive Care Services		
Adult and children age 6 and older Preventive Care Services		
• Routine physical exams	100%; Deductible does not apply	100%; Deductible does not apply
• Adult Immunizations	100%; Deductible does not apply	100%; Deductible does not apply
• Diagnostic Services and procedures	100%; Deductible does not apply	100%; Deductible does not apply
• Routine gynecological exams, including a PAP Test	100%; Deductible does not apply	100%; Deductible does not apply
• Mammograms, annual routine and Medically Necessary and Appropriate	100%; Deductible does not apply	100%; Deductible does not apply
• Colorectal Cancer Screening	100%; Deductible does not apply	100%; Deductible does not apply
• Preventive Care 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 Preventive Care Services		
• Routine physical exams from birth to age 6	100%; Deductible does not apply	Same as Network Services
• Pediatric immunizations from birth to age 18	100%; Deductible does not apply	Same as Network Services

Benefits	Network	Out-of-Network
• Diagnostic Services and procedures from birth to age 6	100%; Deductible does not apply	Same as Network Services
• 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)		
Hospital Inpatient Services		
• Inpatient Services except as noted below	80% after Deductible	80% after Deductible
• Living Donor Kidney Transplant Services	80% after Deductible when you use a Mayo Designated Transplant Provider	NO COVERAGE
There may be a benefit available for travel expenses directly related to a preauthorized Living Donor Kidney Transplant. Please contact Member Service at the telephone number on the back of your member ID card for further information. Restrictions apply.		
• Inpatient Hospital/Facility Bariatric Surgery	**Eligible members age 18 and older:** 80% after Deductible when you use Blue Distinction Centers for Bariatric Surgery **Eligible members age 17 and younger:** 80% after Deductible when you use Network Providers	**Eligible members age 18 and older:** 80% after Deductible when you use an Out-of-Network Participating Provider. Nonparticipating Provider: NO COVERAGE. **Eligible members age 17 and younger:** NO COVERAGE.
Hospital Outpatient Services		
• Outpatient Hospital/Facility Services, except as noted below	80% after Deductible	80% after Deductible
• laboratory Services	80% after Deductible	80% after Deductible
• diagnostic imaging Services	80% after Deductible	80% after Deductible
• Facility billed free-standing ambulatory surgical center Services	80% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
• Outpatient Hospital/Facility Bariatric Surgery	**Eligible members age 18 and older:** 80% after Deductible when you use Blue Distinction Centers for Bariatric Surgery **Eligible members age 17 and younger:** 80% after Deductible when you use Network Providers	**Eligible members age 18 and older:** 80% after Deductible when you use an Out-of-Network Participating Provider. Nonparticipating Provider: NO COVERAGE. **Eligible members age 17 and younger:** NO COVERAGE.
Medical/Surgical Expenses (except office visits)	80% after Deductible	80% after Deductible
Maternity		
• prenatal Hospital/Facility provider Services	100%; Deductible does not apply	Same as Network Services
• prenatal professional Services	100%; Deductible does not apply	Same as Network Services
• Inpatient Hospital/Facility provider Services for: ▪ delivery in a Hospital/Facility ▪ postpartum care	80% after Deductible	80% after Deductible
• professional Services for: ▪ delivery in a Hospital/Facility	80% after Deductible	80% after Deductible
• postpartum care	80% after Deductible	80% after Deductible
Emergency Services		
• Facility charges	80% after Deductible	Same as Network Services
• professional charges	80% after Deductible	Same as Network Services
Ambulance		
• emergency Medically Necessary and Appropriate Services from the place of departure to the nearest medical Facility equipped to treat the condition	80% after Deductible	Same as Network Services
• non-emergency Medically Necessary and Appropriate Services from the place of departure to the nearest medical Facility equipped to treat the condition	80% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
Therapy and Rehabilitation Services		
Occupational Therapy		
• habilitative and rehabilitative office visits	80% after Deductible	80% after Deductible
• habilitative and rehabilitative therapies	80% after Deductible	80% after Deductible
Physical Therapy		
• habilitative and rehabilitative office visits	80% after Deductible	80% after Deductible
• habilitative and rehabilitative therapies	80% after Deductible	80% after Deductible
Speech Therapy		
• habilitative and rehabilitative office visits	80% after Deductible	80% after Deductible
• habilitative and rehabilitative therapies	80% after Deductible	80% after Deductible
Spinal Manipulations – includes office visit	80% after Deductible	80% after Deductible
Other chiropractic Services including therapies	80% after Deductible	80% after Deductible
Other Therapy Services		
• **Professional Services** ▪ Cardiac Rehabilitation ▪ Chemotherapy ▪ Dialysis Treatment ▪ Infusion therapy ▪ Radiation therapy ▪ Respiratory therapy	80% after Deductible	80% after Deductible
• **Hospital Outpatient** ▪ Cardiac Rehabilitation ▪ Chemotherapy ▪ Dialysis Treatment ▪ Infusion therapy ▪ Occupational therapy ▪ Physical medicine ▪ Radiation therapy ▪ Respiratory therapy ▪ Speech therapy	80% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
Mental Health/Substance Abuse Services		
Mental Health Care Services		
• Inpatient professional services	80% after Deductible	80% after Deductible
• Inpatient Hospital/Residental Behavioral Health Treatment Facility Services	80% after Deductible	80% after Deductible
• Outpatient professional Services ▪ office visit	80% after Deductible	80% after Deductible
▪ all other professional Services	80% after Deductible	80% after Deductible
• Outpatient Facility Services	80% after Deductible	80% after Deductible
Substance Abuse Services		
• Inpatient professional Services	80% after Deductible	80% after Deductible
• Inpatient Hospital/Residential Behavioral Health Treatment Facility Services	80% after Deductible	80% after Deductible
▪ Outpatient professional Services ▪ office visits	80% after Deductible	80% after Deductible
▪ all other professional Services	80% after Deductible	80% after Deductible
• Outpatient Facility Services	80% after Deductible	80% after Deductible
Other Services		
Durable Medical Equipment		
• Durable Medical Equipment, except as noted below	80% after Deductible	80% after Deductible
• Insulin pumps, glucometers, and related equipment and devices	80% after Deductible	80% after Deductible
• Orthotics	80% after Deductible	80% after Deductible
• Prosthetics	80% after Deductible	80% after Deductible
Home Infusion and Suite Infusion Therapy Services	80% after Deductible	NO COVERAGE
Home Health Care	80% after Deductible	80% after Deductible
Hospice	80% after Deductible	NO COVERAGE
Assisted Fertilization • office visits	80% after Deductible	80% after Deductible

Benefits	Network	Out-of-Network
• all other eligible professional services	80% after Deductible	80% after Deductible
• Assisted Fertilization benefits are subject to a Lifetime maximum limit of $10,000 per member medical Services and Prescription Drugs combined.		
Skilled Nursing Facility Care	80% after Deductible	80% after Deductible
• Skilled Nursing Facility Care is subject to a combined limit: 120 days per person per Plan Year for all Networks combined.		
Transplant Services	100% of the Transplant Payment Allowance for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) Provider	80% of the Transplant Payment Allowance after Deductible

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

Prescription Drug Benefits	**Retail Pharmacy** Up to 34-day supply, or 100 units, whichever is greater	**Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy** Up to 90-day supply	**Nonparticipating Retail Pharmacy**
Pharmacy Network	Select Pharmacy Network	Participating: 90dayRx Retail and Mail Service Pharmacy	Nonparticipating Pharmacy
• **FlexRx Preferred Generic Prescription Drugs**	$20.00 Copayment per prescription	**90dayRx Participating Retail Pharmacy:** $40.00 Copayment per prescription **Mail Service Participating Pharmacy:** $40.00 Copayment per prescription	$20.00 Copayment per prescription
• **FlexRx Preferred Brand Prescription Drugs**	$35.00 Copayment per prescription	**90dayRx Participating Retail Pharmacy:** $70.00 Copayment per prescription **Mail Service Participating Pharmacy:** $70.00 Copayment per prescription	$35.00 Copayment per prescription

Prescription Drug Benefits	**Retail Pharmacy** Up to 34-day supply, or 100 units, whichever is greater	**Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy** Up to 90-day supply	**Nonparticipating Retail Pharmacy**
Pharmacy Network	Select Pharmacy Network	Participating: 90dayRx Retail and Mail Service Pharmacy	Nonparticipating Pharmacy
• **Non-Preferred Generic Prescription Drugs**	$50.00 Copayment per prescription	**90dayRx Participating Retail Pharmacy:** $100.00 Copayment per prescription **Mail Service Participating Pharmacy:** $100.00 Copayment per prescription	$50.00 Copayment per prescription
• **Non-Preferred Brand Prescription Drugs**	$50.00 Copayment per prescription	**90dayRx Participating Retail Pharmacy:** $100.00 Copayment per prescription **Mail Service Participating Pharmacy:** $100.00 Copayment per prescription	$50.00 Copayment per prescription
• **Retail Pharmacy Vaccine Program** ▪ certain eligible vaccines administered at participating Retail Pharmacy	0% Coinsurance	NO COVERAGE	NO COVERAGE
• **Designated Over-the-Counter (OTC) drugs with a prescription**	0% Coinsurance	NO COVERAGE	NO COVERAGE
• 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 cost-sharing amounts listed above.			
• You are responsible for the payment differential when a Generic Drug is authorized by the Physician and the member purchases a Brand Drug. Your payment is the price difference between the Brand Drug and Generic Drug in addition to the Brand Drug cost-sharing amounts which may apply.			

Prescription Drug Benefits	Retail Pharmacy Up to 34-day supply, or 100 units, whichever is greater	Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy Up to 90-day supply	Nonparticipating Retail Pharmacy
Pharmacy Network	Select Pharmacy Network	Participating: 90dayRx Retail and Mail Service Pharmacy	Nonparticipating Pharmacy
Preventive Medications			
Preventive Covered prescription drugs ▪ FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. ▪ designated preventive drugs with a prescription (such as FDA-approved Tobacco Cessation Drugs and Products, aspirin, folic acid, vitamin D, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the	You pay 0% coinsurance Deductibles, coinsurance and/or Copayments do not apply	You pay 0% coinsurance Deductibles, coinsurance and/or Copayments do not apply	You pay 0% coinsurance Deductibles, coinsurance and/or Copayments do not apply

Prescription Drug Benefits	Retail Pharmacy Up to 34-day supply, or 100 units, whichever is greater	Maintenance Prescription Drugs through Participating: 90dayRx Retail and Mail Service Pharmacy Up to 90-day supply	Nonparticipating Retail Pharmacy
Pharmacy Network	Select Pharmacy Network	Participating: 90dayRx Retail and Mail Service Pharmacy	Nonparticipating Pharmacy
Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.			
• Preventive Covered Prescription Drugs 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 Medical Emergency.

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

No ambulance benefits will be paid for:

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

Anesthesia for Non-Covered Dental Procedures (Limited)

The health care Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide Dental Care to a covered person who is a child under age five (5); is severely disabled; or, has a medical condition that requires hospitalization or general anesthesia for dental Treatment. For Hospital/Facility provider charges please refer to "Hospital Services." Dental Services are not covered unless otherwise noted.

Autism Spectrum Disorders

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

Benefits are provided for medically necessary neurodevelopmental and behavioral treatments and managements, medication, physical therapy, occupational therapy, and speech 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: all physician prescribed Medically Necessary and Appropriate equipment and supplies, including but not limited to: 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 working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association 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 Blue Cross
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

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

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

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

Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per member per Plan year. Deductible does not apply.

Corrective lenses for aphakia.

Eyeglasses/lenses after cataract surgery (purchased within 24 months of cataract surgery).

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

Home Health Care/Hospice Care Services

This health care Plan covers the following Services you receive from a home health care agency, hospice or a hospital program for home health care and/or Hospice Care:

- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and

appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.

- Skilled Nursing Care – 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.

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

Inpatient Services

- Bed and Board

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

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

- Ancillary Services

  Hospital Services and supplies including, but not restricted to:

  - The health care Plan covers anesthesia inpatient Hospital charges when necessary to provide Dental Care to a covered person who is a child under age five (5); is severely disabled; or, has a medical condition that requires hospitalization or general anesthesia for dental Treatment. Dental Services are not covered unless otherwise noted;
  - Communication Services of a private-duty nurse or personal care assistant up to 120 hours per Hospital admission for ventilator-dependent persons;
  - use of operating, delivery and Treatment rooms and equipment;
  - Prescription Drugs and medicines provided to you while you are an inpatient in a Facility provider;
  - whole blood, administration of blood, blood processing, and blood derivatives;
  - anesthesia, anesthesia supplies and Services rendered in a Facility provider by an employee of the Facility provider. Administration of anesthesia ordered by the Attending Health Care Provider and rendered by a Health Care Provider other than the surgeon or assistant at surgery;
  - medical and surgical dressings, supplies, casts and splints;
  - Telemedicine Services;
  - diagnostic Services
  - Living Donor Kidney Transplant Services; or
  - therapy and rehabilitation Services

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

Outpatient Services

- Ancillary Services

  Hospital Services and supplies including, but not restricted to:

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

- Telemedicine Services; and,
- medical and surgical dressings, supplies, casts and splints.

- Pre-Admission Testing

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

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

Emergency Care Services

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

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

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

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

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

Maternity Services

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

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

- Prenatal Care

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

- Complications of Pregnancy

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

- Normal Pregnancy

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

- Nursery Care

  Covered Services provided to the newborn child from the moment of birth, including care which is necessary for the Treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care.

Routine nursery care includes inpatient medical visits by a professional provider. To be covered as a Dependent, the newborn child must be enrolled as a Dependent under this health care Plan. Refer to the "General Information" section for further eligibility information. Please refer to the "Eligibility" section to determine when the newborn's coverage will begin if the newborn is added to the health care Plan.

- Maternity Home Health Care Visit

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

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

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

Medical Dental Services

- 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

- Accident Related Dental Services

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

Medical Services

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

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

Inpatient Medical Services

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

- Concurrent Care

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

- Consultation

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

- Inpatient Medical Care Visits

  Benefits are provided for inpatient medical care visits.

- Intensive Medical Care

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

- Routine Newborn Care

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

Outpatient Medical Care Services (Office Visits)

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

Please note that as a Blue Cross 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
- Telemedicine Services
- Retail site, such as in a pharmacy or other retail store

Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; Physician time; and, psychotherapy.

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

Telemedicine Services may also be referred to as televideo consultations or telehealth Services. These Services are interactive audio and video communications, permitting real-time communication between a distant site Physician or practitioner and the member, who is present and participating in the televideo visit at a remote Facility. For self-injectable prescription medications/drugs, please refer to "Prescription Drugs," except as provided in Medical Policy.

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Blue Cross 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 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 including Telemedicine 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 iIlness.

- Inpatient Medical Services

  Covered inpatient medical Services provided by a Health Care Provider:

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

- Partial Hospitalization Mental Health Care Services

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

- Outpatient Mental Health Care Services

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

  Court-ordered Treatment for mental health care that is based on an evaluation and recommendation for such Treatment or Services by a Physician or a licensed psychologist, is deemed Medically Necessary and Appropriate.

  Court-ordered Treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine Medical Necessity and Appropriateness. Court-ordered Treatment that does not meet the criteria above will be covered if it is determined to be Medically Necessary and Appropriate and otherwise covered under this health care Plan.

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

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

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

- Serious Mental Illness Care Services

  Serious Mental Ilnesses 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). Blue Cross 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 your Blue Cross member website at, www.bluecrossmnonline.com (choose "Live Healthy" tab at the top, then "Preventive Care"), or call Member Service at the telephone number listed on the back of your member ID card.

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

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

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

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

- Adult and Pediatric Care

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

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

- Benefits are provided for “child health supervision services,” which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. We will reimburse five (5) child health supervision visits from birth to 12 months, three (3) child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
- 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, and digital rectal exams for men of all ages: one (1) per Plan year.
- Surveillance tests for ovarian cancer

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

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:

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

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

Surgical Services

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

- Anesthesia

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

- Assistant at Surgery

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

- Surgery
  - Sterilization (please refer to Preventive Care for female sterilization)
  - Surgery performed by a professional provider. Separate payment will not be made for pre-operative and post-operative Services.
  - Reconstructive surgery performed on a Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the Attending Health Care Provider. Congenital means present at birth.
  - Reconstructive surgery which is incidental to or following surgery resulting from Illness of the involved body part.
  - In cases of reconstructive breast surgery following mastectomy, coverage for reconstructive surgery will be provided if the mastectomy is medically necessary as determined by the attending physician.
  - 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 Blue Cross deems that an additional allowance is warranted.

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

- Oral surgery and anesthesia for:
  - removal of impacted teeth
  - removal of a tooth root without removal of the whole tooth
- Root canal therapy
- 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 Blue Cross 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 12 months of either the date of the injury or first date of coverage and is completed within 24 months of the first Treatment
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

Therapy and Rehabilitation Services

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

- Cardiac rehabilitation
- Chemotherapy
- Dialysis Treatment
- Infusion therapy when performed 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):

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

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

- Allogeneic and syngeneic bone marrow transplant and peripheral blood stem cell and umbilical cord blood transplant procedures
- Autologous bone marrow transplant and peripheral blood stem cell transplant procedures
- Heart

- Heart-lung
- Kidney - pancreas transplant performed simultaneously (SPK)
- Liver - deceased donor and living donor
- Liver-kidney
- Lung - single or double
- Pancreas transplant - deceased donor and living donor segmental
    - Pancreas transplant alone (PTA)
    - Simultaneous pancreas - kidney transplant (SPK)
    - Pancreas transplant after kidney transplant (PAK)
- Small-bowel and small-bowel/liver

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

- when both the recipient and the donor are members, each is entitled to the benefits of their health care Plan;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care Plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield 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.

No benefits are payable for:

- Travel expenses for a kidney donor, except as provided herein.
- Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan.

Covered Services - Prescription Drug Program

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

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

A **Retail Pharmacy** is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible Prescription Drugs and diabetic supplies are generally covered up to a 34-day supply, or 100 units, whichever is greater.

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 an equivalent 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");
- Coverage is provided for preferred and non-preferred Antipsychotic Prescription Drugs prescribed to treat emotional disturbance or Mental Illness on the same basis (applicable level) as all other eligible Prescription Drugs. Your Plan does not require you to request continued coverage or make an exception request for preferred or non-preferred Antipsychotic Prescription Drugs to treat emotional disturbance and Mental Illness.
- 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 member 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. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the Treatment of cancer if the drug is recognized for Treatment of cancer in one of the standard compendia or in one article in the medical literature 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, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or preventive prescription drug coverage, please visit www.bluecrossmnonline.com (choose "Live Healthy" tab at the top, then "Preventive Care") or contact Member Service at the telephone number listed on the back of your member ID card.
- Blue Cross 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 (choose "Live Healthy" tab at the top, then "Preventive Care") or contact Member Service at the telephone number listed on the back of your member ID card. If your prescribing Health Care Provider determines that none of the $0 member cost-sharing options available under your health care Plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmnonline.com (sign in and see "Prescription Drugs" under the "Member Resources" tab).
- insulin;
- prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, and lancets;
- certain Prescription Drugs that may require Prior Authorization from Blue Cross.
- If you are prescribed a medication subject to Step Therapy, another eligible medication in the same or 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 our website at www.bluecrossmnonline.com or contact Member Service at the telephone number listed on the back of your member ID card.
- Designated over-the-counter (OTC) drugs are generally covered in a 0 supply as an alternative for similar prescription medications, subject to package limitations, at a retail Participating Pharmacy. OTC drugs are not available through 90dayRx. A current list of designated OTC drugs is available on the 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. When you have reached your Out-of-Pocket Limit, you still pay the difference in cost between the Brand Drug and the Generic Drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. 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 (choose “Shop Plans” tab at the top, then “Prescription Drugs” on the right, select “See All Prescription Drug Programs”, then, “Get Vaccines at a Pharmacy”) or contact Member Service at the telephone number on the back of your member ID card.
- 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.
- Self-administered injectable and oral Prescription Drugs for Assisted Fertilization must be obtained through a Specialty Pharmacy Network supplier and are subject to the lifetime maximum limit of $10,000 per member for all Assisted Fertilization for all charges and Networks combined.
- We may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain Prescription Drugs covered under the health care Plan. Such discounts are the sole property of Blue Cross and will not be considered in calculating any Coinsurance, Copayment, Deductible, or benefit maximums.
- There may be a prescription drug travel refill benefit available if you are traveling for an extended period of time within the United States and/or traveling for an extended period of time outside the United States. Please contact Member Services at the telephone number on the back of your member ID card for further information. Restrictions apply.
- These listings are subject to periodic review and modification by Blue Cross or a designated committee of Physicians and pharmacists.

Specialty Pharmacy Network Supplier

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

  Specialty Prescription Drugs may be ordered by a Health Care Provider on your behalf or you may submit the prescription order directly to the Specialty Pharmacy Network supplier.

***No benefits are payable for the following Services*:**

- 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 Blue Cross is mandated or required to provide based on state or federal law, no benefits will be provided for Services, supplies, Prescription Drugs or charges as noted below.

Exclusions

No benefits will be provided for the following:

1. Services rendered prior to your effective date of coverage.
2. Services which are Experimental/Investigative in nature, except for certain routine care for approved clinical trials.
3. Treatments, Services or supplies which are not Medically Necessary and Appropriate based on the definition of “Medically Necessary and Appropriate” in the “Terms You Should Know” section.
4. Any portion of a charge for a covered services or supply that exceeds the Allowed Amount, except as provided herein.
5. Charges for any other medical or dental Service or Treatment or prescription drug, except as provided herein.
6. 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.
7. Charges incurred after the date of termination of your coverage, except as provided herein.
8. Services for 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.
9. Services that are provided without charge, including Services of the clergy.
10. Services for Dependents if you have Group Member-only coverage.
11. Services that are not within the scope of licensure or certification of a provider.
12. Services that are prohibited by law or regulation.
13. Services received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
14. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical Facility equipped to treat the condition (example: Facility A is the closest medical Facility equipped to treat the condition but you choose to be transported to Facility B. We will cover eligible Medically Necessary and Appropriate ambulance transportation costs that would otherwise apply to transportation to Facility A. If you choose to be transported by ambulance to Facility B, the cost of transportation Services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to Facility A, are not covered under the Plan, and you will be responsible for those costs).
15. Travel, Transportation, or living expenses, whether or not recommended by a Physician, except as specified herein.
16. Ambulance transportation Services that are not Medically Necessary and Appropriate for basic or advanced life support.
17. Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a Physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants.
18. Transportation Services, including ambulance Services that are mainly for your convenience.

19. 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.
20. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
21. 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).
22. Replacement of properly functioning durable medical equipment.
23. Charges for duplicate equipment, prosthetics, and supplies.
24. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
25. Charges for personal and convenience items or items provided at levels that exceed our determination of Medically Necessary and Appropriate for durable medical equipment, supplies, and prosthetics.
26. Charges for: the rental of a manual breast pump; and, electric breast pumps.
27. Services for or related to hearing aids or devices, except as provided herein.
28. Charges for scalp/cranial hair prostheses (wigs) for any diagnosis other than alopecia areata.
29. Charges for blood pressure monitoring devices.
30. Charges for devices for maintenance Services.
31. Room and board expenses in a residential hospice Facility.
32. 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.
33. Services for or related to Skilled Nursing Care - Extended Hours, also referred to as private duty nursing care, except as required by Minnesota law.
34. Charges for Respite Care, except as provided herein.
35. Home infusion Services or supplies not specifically listed as covered Services.
36. Nursing Services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy.
37. Charges for inpatient Admissions which are primarily for diagnostic studies.
38. Personal comfort items such as telephone, television.
39. Communication Services provided on an outpatient basis or in the home.
40. Services and Prescription Drugs for or related to gender selection Services.
41. Services for or related to surrogate pregnancy including: diagnostic screening, Physician Services, reproduction Treatments, and prenatal/delivery/postnatal Services when the pregnant surrogate is not a covered member under this Plan. Refer to “Surrogate Pregnancy” in the “Terms You Should Know” section.
42. Charges for donor ova or sperm.
43. Services for or related to adoption fees.
44. Charges for childbirth classes.
45. Health care professional charges for childbirth deliveries in the home.
46. 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.

47. Services for or related to experimental Infertility Treatment procedures or cryopreservation of eggs or sperm.
48. Services for or related to elective cesarean (C)-section for the purpose of convenience.
49. Services for or related to orthodontia, except as provided herein.
50. Dental services to treat an injury from biting or chewing.
51. Services for osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein.
52. Services, including dental splints, to treat Bruxism.
53. Charges for oral surgery procedures, except as provided herein.
54. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts.
55. Dental implants, and associated services and/or charges, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19.
56. Services for or related to the replacement of a damaged dental bridge from an accident-related injury
57. Accident-related dental services initiated after 12 months from the date of injury or occurring more than 24 months after the date of initial treatment.
58. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as provided herein.
59. Charge for routine dental care, except as provided herein.
60. Custodial Care, domiciliary care, residential care, protective and supportive care including educational Services, rest cures and convalescent care.
61. Services for or related to the LINX™ Reflux Management System for the Treatment of gastroesophageal reflux disease (GERD).
62. Charges for immunizations required for foreign travel or employment.
63. Charges for immunizations, except as provided herein.
64. Charges for the covered patient's failure to keep a scheduled visit.
65. Charges billed by your Provider for the completion of a Claim form.
66. Services rendered by other than ancillary providers, Facility providers or professional providers.
67. 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.
68. Services rendered by a provider who is a member of your Immediate Family.
69. Services performed by a professional provider enrolled in an education or training program when such Services are related to the education or training program.
70. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate.
71. Charges for furnishing medical records or reports and associated delivery charges.
72. Services provided during an E-Visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and, Services that would similarly not be charged for in an onsite medical office visit.
73. Provider initiated e-mail communications.
74. Services provided during a Telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; and, additional communication on the same day as an onsite medical office visit; and Services that would similarly not be charged for in an onsite

medical office visit.

75. Facsimile transmission communications between members and providers.
76. Charges for giving injections that can be self-administered, except as proivded in Medical Policy.
77. Services for or related to gene therapy as a Treatment for inherited or acquired disorders.
78. Services for or related to growth hormone replacement therapy, except for conditions that meet Medical Necessity and Appropriateness criteria.
79. Charges for autopsies.
80. Services for or related to cosmetic health Services or reconstructive surgery and related Services, and Treatment for conditions or problems related to cosmetic surgery or Services, except as specified herein.
81. Fees, dues, nutritional supplements, food, vitamins and exercise therapy for or related to weight loss programs.
82. Travel expenses for a kidney donor, except as provided herein.
83. Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan.
84. Kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan.
85. Separate charges for pre-operative and post-operative care for surgery.
86. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that is not Medically Necessary and Appropriate.
87. Services that do not involve direct patient contact such as delivery charges and recordkeeping.
88. Charges for educational classes or programs, except as required by law.
89. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
90. Services for or related to the repair of scars and blemishes on skin surfaces.
91. Services for reproduction treatments when the number of embryos transferred exceeds the current guidelines developed by the Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine.
92. Charges for administration of self-administered Prescription Drugs and/or injectable insulin, whether by a Physician or other person, except as provided in Medical Policy.
93. Services for the Treatment of learning disabilities.
94. Services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as specified herein.
95. Court ordered Services or confinements by a court or law enforcement officer that are not Medically Necessary and Appropriate, except as specified under Minnesota law.
96. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars.
97. Services for or related for Mental Illness not listed in the most recent addition of the ICD and DSM.
98. Services or confinements ordered by a court or law enforcement officer that are not Medically Necessary and Appropriate.
99. 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.
100. Services for or related to room and board for foster care, group homes, shelter care and lodging programs,

and Skills Training.

101. Services for or related to halfway house services.

102. Services for or related to therapeutic support of foster care (Services designed to enable the foster family to provide a therapeutic family environment pr support for the foster child's improved functioning).

103. Services for therapeutic day care and therapeutic camp Services.

104. Services for hippotherapy (equine movement therapy).

105. Charges for Foot Orthoses, except as provided herein.

106. Charges for routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided herein.

107. Charges for or related to reversal of sterilization.

108. Services for or related to substance abuse or addictions that are not listed in the most recent edition of the ICD and DSM.

109. Services for or related to substance abuse interventions (defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition).

110. Services for or related to Treatment leading to or in connection with sex transformation/gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up Treatment, care, and counseling, unless Medically Necessary and Appropriate as determined by Blue Cross 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.

111. 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, Laser-Assisted in Situ Keratomileusis (LASIK) and all related Services.

112. 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.

113. Maintenance Services.

114. Services for or related to therapeutic massage.

115. Services related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when Medically Necessary and Appropriate and provided by an eligible health care provider.

116. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc., and all related material and products for these programs.

117. Services for or related to therapeutic acupuncture, except for the Treatment of chronic pain; and, nausea associated with surgery, chemotherapy, or pregnancy.

118. Charges for living donor organ and/or tissue transplants, except as provided herein.

119. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.

120. Services for or related to fetal tissue transplantation.

121. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral

stem cell transplant procedures that are considered investigative or not Medically Necessary and Appropriate.

122. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding, and as provided herein.
123. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
124. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
125. Tobacco cessation drugs and products without a prescription.
126. 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.
127. Specialty drugs not purchased through a specialty pharmacy network supplier.
128. Drugs removed from the Preferred drug list due to safety reasons may not be covered.
129. Any charges by any pharmacy provider or pharmacist, except as provided herein.
130. Charges for investigative or non-Food and Drug Administration (FDA) approved drugs, except as specified by law.
131. Any amounts above the Deductible, Coinsurance, Copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
132. Any prescription for more than the retail days supply or 90dayRx days supply as outlined in the “Summary of Benefits” section, except as provided herein.
133. 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.
134. Vitamin or dietary supplements, except as provided herein.
135. Charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
136. Charges for food supplements.

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 Blue Cross 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 Blue Cross before Services are received. For specific details, see your "Summary of Benefits" section.

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

Out-of-Area Care

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

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

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

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

General Provider Payment Methods

Participating Providers

Several industry-standard methods are used to pay our 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 we determine by comparing market prices (for Generic Drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

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

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with Blue Cross or another Blue Cross and/or Blue Shield Plan. For Services received from a Nonparticipating Provider (other than those described under "Special Circumstances" below), the Allowed Amount will be based upon one of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar Service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield Plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by Blue Cross. The Allowed Amount for a Nonparticipating Provider is usually less than the Allowed Amount for a Participating Provider for the same Service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the health care Plan and you are responsible for paying the Nonparticipating Provider. The only exception to this stated in "General Information," "Whom We Pay." 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, Blue Cross 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
Blue Cross Pays:	80% ($80)	60% ($48)
Coinsurance You Owe:	20% ($20)	40% ($32)
Difference Up to Billed Charge You Owe:	None	$70 ($150 minus $80)
You Pay:	$20	$102

Special Circumstances

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

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

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

Women's Health and Cancer Rights Act

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

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

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

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

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

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

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

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

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

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

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

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

Coverage of Health Care Services on the Basis of Gender

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

Inter-Plan Programs

Out-of-Area Services

Overview

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

When you receive care outside Blue Cross' service area, you will receive it from one of two kinds of providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. Blue Cross explains below how we pay both kinds of providers.

Inter-Plan Programs Eligibility – Claim Types

All Claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care benefits except when paid as medical Claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Blue Cross 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, Blue Cross will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you receive covered health care Services outside Blue Cross' service area and the Claim is processed through the BlueCard Program, the amount you pay for covered health care Services is calculated based on the lower of:

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

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

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

Special Cases: Value-Based Programs

BlueCard® Program

- If you receive covered health care Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross 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, Blue Cross will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

Nonparticipating Providers Outside Blue Cross' Service Area

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

Blue Cross Blue Shield Global Core

- If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a Network of inpatient, outpatient and professional providers, the Network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the Claims yourself to obtain reimbursement for these Services.
- If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

- In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient Services, except for your Deductibles, coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to initiate 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 Blue Cross to obtain Precertification for non-emergency inpatient Services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

- When you pay for covered health care Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core Claim form and send the Claim form with the provider's itemized bill(s) to the service center (the address 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 Blue Cross, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

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. We consider educational background, office procedures and performance history to determine eligibility. Then we monitor care on an ongoing basis through office record reviews and member satisfaction surveys.

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

Remember:

If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive Network care. You may want to double-check any provider recommendations to make sure the doctor or Facility provider is in the Network. Your provider directory lists Network Providers in our service area and may change from time to time, including as providers or Blue Cross initiate or terminate Network contracts. Prior

to receiving Services, it is recommended that you verify your Provider's Network status with Blue Cross, including whether the Provider is a Network Provider for your particular Plan. Not every provider is a Network Provider for every Plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Sign in" then "Find a Doctor") or call the Member Service toll-free telephone number listed on the back of your member ID card. For benefit information, refer to the "Summary of Benefits.

How to Get Your Physicians' Professional Qualifications

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

Eligible Providers

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

Network Pharmacies

- **Retail Pharmacy:** Participating retail pharmacies have an arrangement with Blue Cross 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 are temporarily away from home (e.g., vacation) 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. There may be a prescription drug travel refill benefit available if you are traveling for an extended period of time within the United States and/or traveling for an extended period of time outside the United States. Please contact Member Services at the telephone number on the back of your member ID card for further information. Restrictions apply.

- **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 (1) 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 (5) days to get your prescription after it has been processed.Your mail order will include directions for ordering refills.

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

Health Care Management

Medical Management

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

Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required.

Prior Authorization

Prior Authorization is a process that involves a benefits review and determination of Medically Necessary and Appropriate before a Service is rendered. The Blue Cross Prior Authorization list describes the Services for which Prior Authorization is required. The Prior Authorization list is subject to change due to changes in Blue Cross' medical policy. Blue Cross 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 Blue Cross website at www.bluecrossmnonline.com or call Member Service at the telephone number listed on the back of your member ID card. They will direct your call.

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

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

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

We require that you or the provider contact us at least 10 working days prior to the provider scheduling the care/Services to determine if the Services are eligible. We will notify you of our decision within 10 working days, provided that the Prior Authorization request contains all the information needed to review the Service.

Expedited review determination

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

We prefer that all requests for Prior Authorization be submitted to us 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 us 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 Minnesota Out-of-Network Participating Providers are required to provide preadmission notification for you. If those Providers do not provide preadmission notification for you, then those Providers are responsible for the charges.

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

Preadmission notification is required for the following Admissions/facilities:

1. Hospital acute care Admissions (medical and behavioral); and,
2. Residential Behavioral Health Treatment Facilities.

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

Preadmission Certification

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

All Network Providers and Minnesota Out-of-Network Participating Providers are required to provide preadmission certification for you. If those Providers do not provide preadmission certification for you, then those Providers are responsible for the charges.

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

Preadmission certification is required for the following Admissions/facilities:

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

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

Emergency Admission Notification

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

All Network Providers and Minnesota Out-of-Network Participating Providers are required to provide emergency admission notification for you. If those Providers do not provide preadmission certification for you, then those Providers are responsible for the charges.

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

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

Continuity of Care

Continuity of Care for New Members

If you are a member of a group that is new to Blue Cross, 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 with us. We 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. We 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

Blue Cross will assist you in making the transition from an Out-of-Network to a Network Provider if you request us 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) accept Blue Cross' Allowed Amount; 2) adhere to all Blue Cross Prior Authorization requirements; and, 3) provide Blue Cross with necessary medical information related to your care.

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

Termination by Provider

If your provider terminates its contract with Blue Cross, we 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.

Provider Termination for Cause

If we have terminated our relationship with your provider for cause, we 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 with Blue Cross, this section applies to you. If the relationship between your Network clinic or Physician and Blue Cross ends, rendering your clinic or provider Out-of-Network with us, and the termination was by Blue Cross and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to a Participating Provider as required under the terms of your coverage with us. We 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. We 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

Blue Cross will assist you in making the transition from an Out-of-Network to a Network Provider if you request us 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) accept Blue Cross' Allowed Amount; 2) adhere to all Blue Cross Prior Authorization requirements; and, 3) provide Blue Cross with necessary medical information related to your care.

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

Termination by Provider

If your provider terminates its contract with Blue Cross, we 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.

Provider Termination for Cause

If we have terminated our relationship with your provider for cause, we 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

Entire Contract

This booklet, including the endorsements and the attached papers if any, documents incorporated by reference and the group contract issued to the Group Contractholder make up the entire contract of coverage. The master group contract is available for your inspection at your Group Contractholder's office. Your Group Contractholder is the Plan Administrator for your health care Plan. We have discretionary authority to determine your eligibility for benefits and to construe the provisions of the group contract and this booklet. All statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a Claim under the contract, unless it is contained in the written application. This booklet is issued and delivered in the state of Minnesota. It is subject to the substantive laws of the state of Minnesota, without regard to its choice of law principles; and, it is not subject to the substantive laws of any other state.

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.

Carrier Replacement

If you were covered under a fully-insured health Plan prior to the effective date of this health care Plan, the Minnesota Carrier Replacement law applies. Under the Minnesota Carrier Replacement law, you cannot be denied benefits solely because there has been a change in the carrier providing coverage to the Group Contractholder's group.

If you are inpatient on the effective date of this coverage, the prior carrier is responsible for all eligible expenses until your final discharge from the inpatient Facility provider or until contract maximums have been met.

In applying any Deductible or Waiting Period, this health care Plan gives credit for the full or partial satisfaction of the same or similar provisions under the prior contract.

Time Limit for Misstatements

If there is any misstatement in the written application that the Group Contractholder completes, we cannot use the misstatement to cancel coverage that has been in effect for, or deny a Claim incurred on a date that is on or after, two (2) years or more from the initial date of coverage issued as a result of that application. This time limit does not apply to fraudulent misstatements.

Changes to the Contract

The Group Contractholder reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to 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. The group contractholder may add/change eligible classes of employees from time to time, and such changes will be noted in the Group Contract. Any amendment to this health care Plan may be effected by a written resolution adopted by the Plan Administrator. Blue Cross will communicate any adopted changes to the Group Contractholder.

All changes to the group contract must be approved in writing by one (1) of our executive officers and attached to the group contract with the Group Contractholder. No agent can legally change the group contract or waive any of its terms.

Legal Actions

No action at law or in equity shall be brought to recover on this health care Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this health care Plan found in "How to

File a Claim". No legal action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Third Party Payments of Premium and/or Cost-Sharing

As required by law, Blue Cross will accept premium and cost-sharing payments made on behalf of enrollees by the following persons/entities:

1. the Ryan White HIV/AIDS Program;
2. other Federal and State government programs (or grantees) that provide premium and cost-sharing support for specific individuals; and
3. Indian tribes, tribal organizations, and urban Indian organizations.

Blue Cross may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly* by any other person or entity from which Blue Cross is not required by law to accept third-party premium and/or cost-sharing payments. "Payments" include those made by any means, for example: cash, check, money order, credit card payment, electronic fund transfer, etc. Third parties not listed above (or from whom Blue Cross is not required by law to accept third-party payment) are referred to as "ineligible third parties." For purposes of clarity, but not limitation, commercial (or for-profit) entities, Hospitals, and other healthcare providers (including, without limitation, suppliers) are ineligible third parties. Religious institutions and other not-for-profit organizations may also be considered ineligible third parties.

Any cost-sharing paid by ineligible third parties will not be counted toward an enrollee’s deductible or out-of-pocket maximum. "Cost-sharing" includes payments such as deductibles, copayments and coinsurance. Blue Cross may make retroactive adjustments to account for any payments made by ineligible third parties.

You are required to immediately notify Blue Cross of any change in your (or your Dependent(s)) information submitted in connection with the application for coverage or otherwise provided with respect to any third-party payment.

Any person or entity that violates these restrictions and/or makes any ineligible third party payment described above will be held responsible for and will be required to reimburse Blue Cross for all costs associated with the relevant Plan or policy related to the violation or ineligible payment.

Blue Cross maintains sole discretion with respect to its acceptance of third-party payments. Blue Cross may make changes to its administration of same at any time and as otherwise needed to support compliance with law and/or applicable regulatory guidance.

If you have questions about this third-party payment policy or whether Blue Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at the number located on the back of your ID card.

*Indirect payments include, for example, an ineligible third-party making a check out to or otherwise paying the enrollee to permit the enrollee to pay amounts due to Blue Cross.

Whom We Pay

When you or your Dependents use a Network Provider for Covered Services, we pay the provider. When you or your Dependents use a Nonparticipating Provider either inside or outside the state of Minnesota for Covered Services, we pay you. You may not assign your benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that we pay a Nonparticipating Provider for Covered Services for a child. When we pay the provider at the request of the custodial parent, we have met our obligation under the contract. This provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and certain out-of-state institutional and medical/surgical providers. You also may not assign your right, if any, to commence legal proceedings against Blue Cross.

In the event of loss of life, if you used an Out-of-Network Provider, we will pay for Covered Services in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to your estate. Any other outstanding payments for Covered Services unpaid at the time of your death may, at your option, be paid either to such beneficiary or to such estate. All other payments for Covered Services will be payable to you. Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to you. The

consent of the beneficiary is not required to surrender or assign benefits under this booklet or to change the beneficiary or make other changes in this booklet.

Blue Cross does not pay Claims to providers or to members 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 are authorized by OFAC.

No Third-Party Beneficiaries

The benefits described in this Plan are intended solely for the benefit of you and your covered Dependents. No one else may Claim to be an intended or third-party beneficiary of this Plan. No one other than you or your Dependent may bring a lawsuit, Claim or any other cause of action related in any way to this Plan, and you may not assign your rights to any other person.

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 Blue Cross as provided by law. Payment made for a specific Service or erroneous payment shall not make Blue Cross or the Group Contractholder liable for further payment for the same Service.

Medical Policy Committee and Medical Policies

Our 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 Blue Cross' policies in effect at the time Treatment is rendered. Prior Authorization may also be required. Our medical policies can be found at the member website and are hereby incorporated by reference.

Who is an Eligible Dependent

NOTE: If both you and your spouse are Group Members of the Group Contractholder, 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.

Spouse

Spouse, meaning:

1. 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 or your spouse continuously from birth and are financially dependent upon you or your spouse
- Children legally placed for adoption

- Legally adopted children and children for whom the employee or the employee's spouse is the child’s legal guardian
- Foster children
- Children awarded coverage pursuant to an order of court

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

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, we may request proof again two (2) years later, and each year thereafter; and,
- must have become disabled prior to reaching the limiting age.

Disabled Dependents

Disabled Dependents if both of the following apply:

- incapable of self-sustaining employment by reason of developmental disability, Mental Illness or disorder, or physical disability; and
- chiefly dependent upon the Group Member for support and maintenance.

Effective Date of Coverage

Coverage starts on the date specified in the llower right hand corner of the front cover. This is the effective date for the group member and any dependents who were enrolled by written application before that date.

Coverage for the group member and any dependents who are eligible on the effective date of the contract begins on that date. Group members and dependents added after the original effective date of the contract are subject to the requirements outlined below:

1. When the group contractholder pays the entire monthly premium:
    - If we receive written application more than 30 days after you or your dependents become eligible (including instances where coverage has been waived), coverage will be effective on your or your dependents' eligibility date. We will backdate coverage for up to two (2) months from the date that we are notified to add you or your dependents. If your group contractholder has a graded contribution, we will not backdate coverage.
2. When you are responsible for all or a portion of the premiums:
    - If we receive your written application more than 30 days after you become eligible, you and your eligible dependents must reapply for coverage at the next open enrollment unless you meet the requirements of the Special Enrollment Period.

Adding New Dependents

We require payment of any required premiums and a written application, on our application form, to add a new dependent. Monthly premiums must be paid from the date coverage begins. This part outlines the time periods for application and the date coverage begins.

Adding a Spouse

When the Group Contractholder pays the entire monthly premium:

- Your spouse is covered starting on the date of marriage if you submit written application within 30 days after marriage. If we receive the application more than 30 days after the marriage, we backdate coverage to the date of marriage or two (2) months, whichever is less.

When you are responsible for all, or a portion of, the premiums:

- Your spouse is covered starting on the date of marriage if you submit payment of required premiums and written application within 30 days after marriage.
- If we receive written application to add your spouse more than 30 days after marriage, your spouse must reapply for coverage at the next open enrollment unless your spouse meets the requirements of the Special Enrollment Period.

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

Your newborn child or newborn grandchild is covered starting on the date of birth. In order to avoid Claim delays, we request that you submit payment of all required premiums and written application within 30 days after birth. If you submit an application more than 30 days after birth, your newborn child or newborn grandchild will still be added retroactive to the date of birth and you will be responsible for any premium due from the date of birth.

Your adopted or foster child is covered starting on the date of adoption or placement with you for adoption or foster care. In order to avoid Claim delays, we request that you submit payment of all required premiums and written application within 30 days after adoption or placement. If you submit an application more than 30 days after adoption or placement, your adopted or foster child will still be added retroactive to the date of adoption or placement and you will be responsible for any premium due from the date of 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

Disabled Dependents who are not currently covered under this booklet, may be added as long as they otherwise meet the definition of "Dependent" as found in the "Terms You Should Know" section. Coverage starts on the first day of the contract month after we receive the written application and monthly premium. Disabled Dependents added to the coverage under this booklet cannot be denied coverage.

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

Special Enrollment Periods

Special enrollment periods are periods when an eligible Group Member or Dependent may enroll in the health Plan under certain circumstances **after they were first eligible for coverage**. In order to enroll the eligible Group Member or Dependent **must notify Blue cross within 30 days** 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, in order to avoid Claim delays, you should request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or Rescission): • Loss of eligibility for employer-sponsored coverage • Plan no longer offers benefits • Termination of all employer contributions • Termination of employment or reduction in hours • Legal separation or divorce • Loss of Dependent child status • Death of employee or primary contractholder • Move outside HMO or ACO service area • Exceeding the Plan's Lifetime Maximum • Employer bankruptcy • COBRA exhaustion • Employee becomes entitled to Medicare
Minimum Essential Coverage includes coverage under specified government sponsored Plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a Dependent due to marriage.
Gaining a Dependent due to birth, adoption, placement for adoption, or placement for foster care.
An individual loses or gains eligibility for Medical Assistance (Medicaid) or Children’s Health Insurance Program (CHIP).
Child support order or other Court order to provide coverage.

Changes in Membership Status

For Blue Cross 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.

Medicare

Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed in a group with 20 or more employees, you will remain covered under the health care Plan for the same benefits available to employees under age 65. As a result:

- the health care Plan will pay all eligible expenses first; then,
- Medicare will pay for Medicare eligible expenses, if any, not paid for by the health care Plan.

- or -

Non-Covered Active Employees Age 65 or Over

If you are age 65 or over and actively employed, you may elect not to be covered under your health care Plan. In such a case, Medicare will be your only coverage. If you choose this option, you will not be eligible for any benefits under the health care Plan. Contact your Plan administrator for specific details.

Spouses Age 65 or Over of Active Employees

If you are actively employed in a group with 20 or more employees, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three (3) months prior to becoming age 65. If you elect to be covered under the health care Plan, you may wait to enroll for Medicare Part B. You will be able to enroll for Part B later during special enrollment periods without penalty.

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 group's health care Plan 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 Under the Employer Contract

Your coverage can be terminated in the following instances:

1. When you cease to be an employee, the group shall promptly notify Blue Cross that you are no longer eligible for coverage and that your coverage should be terminated as follows:
    a. When prompt notification is received, coverage will be terminated no earlier than the date on which you cease to be eligible.
    b. When a group requests a retroactive termination of coverage, coverage will be terminated no earlier than the first day of the month preceding the month in which Blue Cross received notice from the group.
2. When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.
3. If coverage is terminated for all Group Members in your health care Plan, we will give all Group Members a 30-day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months. We will not give this notification if we have reasonable evidence to indicate that this coverage will be replaced by a similar policy, Plan or contract.
4. If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Blue Cross may, upon 30-day advance written notice to you, terminate your coverage under the health care Plan.

Benefits After Termination of Coverage

If you are an inpatient on the day your coverage terminates due to the replacement of the group contract, benefits for inpatient Covered Services will be continued as follows:

- Until the maximum amount of benefits has been paid; or
- Until the inpatient stay ends; or
- Until you become covered, without limitation as to the condition for which you are receiving Inpatient Care, under another group health care Plan; whichever occurs first.

Continuation of Coverage

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

Qualifying Events

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

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

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

- The death of the ***Group Member***.
- A termination of the ***Group Member's*** employment (as described above) or reduction in the ***Group Member's*** hours of employment.
- Entering of decree or judgment of divorce or legal separation from the ***Group Member***. (This includes if the ***Group Member*** 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 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 ***Group Member*** becomes enrolled in Medicare.
- The ***Group Member*** becomes Totally Disabled (as defined above).

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

Your Notice Obligations

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

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

If you or your Dependents do not provide this required notice, any Dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your Dependents do not provide this required notice, you or your Dependent must reimburse any Claims mistakenly paid for expenses incurred after the date coverage actually terminates.

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

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

Group Contractholder's and Plan Administrator's Notice Obligations

The Group Contractholder has 30 days to notify the Plan administrator of events they know have occurred, such as termination of employment or death of the ***Group Member***. This notice to the Plan administrator does not occur when the Plan administrator is the ***Group Contractholder.*** 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 Group Contractholder 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 ***Group Member's*** termination of employment (other than for gross misconduct), reduction in hours, death, or the ***Group Member's*** becoming enrolled in Medicare.

Election Procedures

You and your Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after you or your family member receive notice of the right to elect continuation coverage. *If you or your Dependents do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage*. If your qualifying event is the death of the employee, then you will be given a grace period of 90 days from the date you receive notice of the premium requirement.

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 ***Group Member*** does not elect continuation coverage.

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

How to Elect

Contact the Group Contractholder to determine how to elect continuation coverage.

Type of Coverage

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

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

Maximum Coverage Periods

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

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

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

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

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee. If the qualifying event for continuation is the ***Group Member's*** Total Disability, the administration fee is not permitted. All premiums are paid directly to the Group Contractholder.

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

  Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the ***Group Member's*** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the group contract 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 ***Group Member'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 ***Group Member's*** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month or an indefinite maximum coverage period. The extension applies to the ***Group Member's*** Dependents who are qualified beneficiaries.

  When a second qualifying event occurs that gives rise to a 36-month maximum coverage period for the Dependent, the maximum coverage period (for the Dependent) becomes three (3) years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension will occur.

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

- ***Pre-Termination or Pre-Reduction Medicare Enrollment:*** This extension applies when the qualifying event is the reduction of hours or termination of employment that occurs within 18 months after the date of the ***Group Member's*** Medicare enrollment. The extension applies to the ***Group Member's*** Dependents who are qualified beneficiaries.

  If the qualifying event occurs within 18 months after the ***Group Member*** becomes enrolled in Medicare, regardless of whether the ***Group Member's*** Medicare enrollment is a qualifying event (causing a loss of coverage under the group contract), the maximum period of continuation for the ***Group Member's*** Dependents who are qualified beneficiaries is three (3) years from the date the ***Group Member*** became enrolled in Medicare. Example: ***Group Member*** becomes enrolled in Medicare on January 1. ***Group Member's*** termination of employment is May 15. The ***Group Member*** is entitled to 18 months of continuation from the date coverage is lost. The ***Group Member's*** Dependents are entitled to 36 months of continuation from the date the ***Group Member*** 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.

- ***Group Contractholder'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, we include it here. If the Group Contractholder files Chapter 11 bankruptcy, it may trigger COBRA

coverage for certain retirees and their related qualified beneficiaries. A retiree is entitled to coverage for life. The retiree's spouse and Dependent children are entitled to coverage for the life of the retiree, and, if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's spouse is covered by the group contract, then that surviving spouse is entitled to coverage for life.

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the ***Group Member*** and Dependents will automatically terminate when any one (1) of the following events occur:

- The Group Contractholder no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit Claims) that permits termination of coverage for cause with respect to any covered ***Group Members*** 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 Group Member During Continuation Period

A child born to, adopted by or placed for adoption with a covered ***Group Member*** during a period of continuation coverage is considered to be a qualified beneficiary provided that the covered ***Group Member*** 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 ***Group Member***.

Open Enrollment Rights and Special Enrollment Rights

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Questions

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

Overview

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

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Group Member and Dependents	Earlier of: 1. 18 months, or 2. Enrollment Date in other group coverage.
Divorce or legal separation	Ex-spouse/spouse and any Dependent children that lose coverage	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end.
Death of Group Member	Surviving spouse and Dependent children	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end if the Group Member had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to the Group Member's enrollment in Medicare	All Dependents	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the Group Contractholder filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation.
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Total Disability of Group Member	Group Member and Dependents	Earlier of: 1. Date Total Disability ends, or 2. Date coverage would otherwise end.

Qualifying Event	Who May Continue	Maximum Continuation Period
Extensions to 18-month maximum continuation period: Total disability of Dependent(s)	Disabled Dependent and all other covered family members	Earliest of: 1. 29 months after the Group Member leaves employment, or 2. Date total disability ends, or 3. Date coverage would otherwise end.

Coordination of Benefits

This section applies when you have health care coverage under more than one (1) Plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which Plan determines benefits first. Your benefits under This Plan are not reduced if the Order of Benefits Rules require This Plan to pay first. Your benefits under This Plan may be reduced if another Plan pays first.

Definitions

These definitions apply only to this section.

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

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

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

   c. individual coverage.

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

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

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

2. "This Plan" means the part of the 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 and Appropriate 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

Most health care Plans, including your health care Plan, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered Dependents are eligible for payment under more than one health care Plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision in your Blue Cross coverage works:

1. When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your health care Plan.
2. When the person who received care is covered as an employee under one contract, and as a Dependent under another, then the employee coverage pays first.
3. When a Dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the Calendar Year pays first. But, if both parents have the same birthday, the health care Plan which covered the parent longer will be the primary health care Plan. If the Dependent child's parents are separated or divorced, the following applies:
   a. The parent with custody of the child pays first.
   b. The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
   c. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
4. When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
   a. the benefits of a health care Plan covering the person as an employee other than a laid-off or retired employee or as the Dependent of such person shall be determined before the benefits of a health care Plan covering the person as a laid-off or retired employee or as a Dependent of such person and if,
   b. the other health care Plan does not have this provision regarding laid-off or retired employees, and, as a result, Plans do not agree on the order of benefits, then this rule is disregarded.
5. When the person who received care is covered under the No-Fault Automobile Insurance Act or similar law or traditional automobile "Fault" type coverage, that coverage applies benefits first.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Prescription drug benefits are not coordinated against any other health care or prescription drug benefit coverage.

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.

Reimbursement and Subrogation

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

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

Notice Requirement

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

Duty to Cooperate

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

Release of Records

You agree to allow all Health Care Providers to give us needed information about the care they provide to you. This includes information about care received prior to my enrollment with Blue Cross where necessary. We 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. We keep this information confidential, but we may release it if you authorize release, or if state or federal law permits or requires release without your authorization. If a provider requires special authorization for release of records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your Claim.

Identification Card

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

How to File a Claim

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

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

Right of Examination

We have the right to ask you to be examined by a provider during the review of any Claim. We choose the provider and pay for the exam whenever we request this. Failure to comply with this request may result in denial of your Claim.

Your Explanation of Benefits Statement

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

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

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

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

How to Voice a Complaint

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

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

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

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

Fraud or Provider Abuse

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

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

Authorized Representatives

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

Requests for Precertification and Other Pre-Service Claims

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

Requests for Reimbursement and Other Post-Service Claims

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

Determinations on Benefit Claims

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

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

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

Blue Cross will notify you in writing of its determination on your request for reimbursement or other post-service Claim within a reasonable period of time following receipt of your Claim. That period of time will not exceed 30 days from the date your Claim was received. However, this 30-day period of time may be extended one (1) time by Blue Cross for an additional 15 days, provided that Blue Cross determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for Blue Cross to make a decision on your post-service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service Claim.

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

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

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

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

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

Standard Exception Requests

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

Expedited Exception Requests Based on Exigent Circumstances

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

External Review of a Standard or Expedited Exception Request

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

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

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

Appeal Process

Introduction

As described below, Blue Cross has two (2) different processes to resolve appeals: one for appeals that do not require a medical determination; and, one for appeals that do require a medical determination. With an exception described below, you are required to submit a first level appeal before you can exercise any other rights to appeal or other review. If the decision on that first level review is wholly or partially adverse to you, you may either file a second level appeal within Blue Cross or you may seek review external to Blue Cross. If you choose to file a second level appeal within Blue Cross, and that decision is wholly or partially adverse to you, you can then seek external review. There is an exception for cases that qualify for an expedited appeal. For those cases, you may seek external review at the same time you request an expedited first level appeal.

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

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

Definitions

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

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

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

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

First Level Appeals That Do Not Require a Medical Determination

First Level Oral Complaint

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

First Level Written Appeals

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

We will inform you of our decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will

inform you of the reasons for the extension. You have the right to review the information that we relied on in the course of the appeal.

First Level Appeals That Require a Medical Determination

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

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

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

Definitions

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

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

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

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

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

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

Standard First Level Appeal

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

Expedited First Level Appeal

When Blue Cross' initial determination to not certify a health care Service is made prior to or during an ongoing Service requiring review and the Attending Health Care Provider believes that an expedited appeal is warranted, you and your Attending Health Care Provider may request an expedited appeal. You and your Attending Health Care Provider may appeal the determination over the telephone. Our appeal staff will include the consulting Physician or Health Care Provider if reasonably available. When an expedited appeal is completed, we will notify you and your Attending Health Care Provider of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from our receipt of the expedited appeal request. If we decline to reverse our initial determination not to certify, you will be notified of your right to submit the appeal to the external review process described below.

Second Level Appeals to Blue Cross Internal Appeals Committee

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

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

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

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

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

If you request a hearing, you or any person you choose may present testimony or other information. We will provide you written notice of our decision and all key findings within 45 days after we receive your written request for a hearing.

External Review

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

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

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East, Suite 280
St. Paul, MN 55101-2198

The external review entity will notify you and Blue Cross that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and Blue Cross must provide the external review entity any information to be considered. Both you and Blue Cross will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, Blue Cross, and the Commissioner within 45 days of receiving the request for external review. The external review entity's decision is binding on Blue Cross, but not binding on you.

Expedited External Review

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

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

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

Member Service

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

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

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

Terms You Should Know

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

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

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

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

Allowed Amount - The amount that payment is based on for a given Covered Service of a specific provider. The Allowed Amount may vary from one provider to another for the same Service. All benefits are based on the Allowed Amount, except as specified in the "Summary of Benefits." For Network Providers, the Allowed Amount is the negotiated amount of payment that the Network Provider has agreed to accept as full payment for a Covered Service at the time your Claim is processed. We 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, we 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 us, and the percentage of the Allowed Amount paid by us is lower than the stated percentage for the Covered Service. If the payment to the provider is increased, we pay 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. Blue Cross will pay the stated percentage of the Allowed Amount for a Covered Service. In most cases, Blue Cross will pay this amount to you. The determination of the Allowed Amount is subject to all business rules as defined in our Provider Policy and Procedure Manual. As a result, we 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 Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar Service; (3) a percentage of billed charges; or, (4) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by Blue Cross.

The Allowed Amount for 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 Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar Service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same or similar Service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield Plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge or Medicare Advantage Allowed Charge is not available, the pricing method may also be determined by factors such as type of Service, Place of Service, reason for care, and type of provider at the point the Claim is received by Blue Cross.

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, Blue Cross 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 Blue Cross.

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 one of our 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.

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

Covered Maintenance Prescription Drug - A Maintenance Prescription Drug, which Blue Cross 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.

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

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

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 Blue Cross 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; and,
4. determined to be reasonable and necessary; and, represents the most cost-effective alternative.

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

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

Experimental/Investigative - The use of any Treatment, Service, procedure, Facility, equipment, prescription drug, device or Supply (intervention) which is not determined by Blue Cross to be medically effective for the condition being treated. Blue Cross 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 Cross 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 Blue Cross.

Group Contractholder - The employer or association to which the group contract 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 Group Contractholder. 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 Blue Cross is contractually obligated to pay or provide as a benefit to you under this health care Plan when dispensed by a participating maintenance pharmacy. Any prescription order for not more than a 90-day supply of a legend prescription drug shall be considered a Maintenance Prescription Drug, unless otherwise expressly excluded.

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

Medical Emergency - Medically Necessary and Appropriate care manifesting itself by acute symptoms of sufficient severity, including severe pain, such that 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) – With respect to services other than mental health care Services: 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. Blue Cross 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 Blue Cross determines that the Service, supply or covered medication is Medically Necessary and Appropriate.

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

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

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

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

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

- When you receive Services within the health care Plan service area, the designated Network for professional providers and Facility providers is the Aware Network.
- When you receive Services within the Blue Cross Service area, the designated Network for professional providers and Facility providers is the Aware Network.
- When you receive Services outside Minnesota, the designated participating Network for professional providers and Facility providers is the local BlueCard Traditional Network.

Network Provider - An ancillary provider, professional provider or Facility provider who has entered into an agreement, either directly or indirectly, with Blue Cross 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.

Nonparticipating Provider - A provider who has not entered into a Network contract with us or the local Blue Cross and/or Blue Shield Plan.

Out-of-Network Participating Provider - Providers who have a contract with us 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 us 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 - Refers to Blue Cross; which is an independent licensee of the Blue Cross and Blue Shield Association. Any reference to the Plan may also include its Designated Agent as defined herein and with whom the Plan has contracted, either directly or indirectly, to perform a function or service in the administration of this health care Plan.

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

Precertification (Prior Authorization) - The process through which selected Covered Services are pre-approved by Blue Cross.

Preferred Drug List - 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 cost-sharing amounts listed in the "Summary of Benefits" section.

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

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

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A Facility licensed under state law in the state in which it is located that provides inpatient Treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse, or substance addiction. The Facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A Residential Behavioral Health Treatment Facility does not, other than incidentally, provide educational or recreational Services as part of its Treatment program.

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

Retail Health Clinic - A clinic located in a retail establishment or worksite that provides medical Services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek Services from a Physician or Facility provider. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible Health Care Providers that have a practice arrangement with a Physician. The list of available medical Services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic Services is available on a walk-in basis.

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

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

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

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

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

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

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing his or her Illness, Treatment, and the requirements of everyday independent living.

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

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

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

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

Substance Abuse and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current 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 and Appropriate for the medical Treatment or diagnosis of an Illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.
Supplies do not include such things as:

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

Surrogate Pregnancy - An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

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

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

Totally Disabled (or Total Disability) - A condition resulting from Illness or injury as a result of which, and as certified by a Physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "Totally Disabled"

(or Total Disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of Total Disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a Physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "Totally Disabled" (or Total Disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

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

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

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

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

You are hereby notified, your health care benefit program is between the Group, 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 Group, on behalf of itself and its employees, for any Blue Cross Blue Shield obligations under your health care benefit program.

NOTICE OF PRIVACY PRACTICES

BlueCross BlueShield MInnesota

FOR YOUR PROTECTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) have always been committed to maintaining the security and confidentiality of the information we receive from our members. Whether it's your medical information or other identifiable information (such as your name, address, phone number or member identificationnumber) ("protected health information"), we maintain policies and procedures, and other electronic controls, to guard against unauthorized access and use, and unnecessary collection of information. You should know that we are required by law to provide you this notice about our legal duties and privacy practices. We hope that this notice will clarify our responsibilities to you and provide you with a good understanding of your rights.

Please Note: This notice does not apply to members whose employers are self-insured. If your employer is self-insured, you need to contact your employer for more information about your health plan's privacy practices.

HOW BLUE CROSS SAFEGUARDS YOUR PROTECTED HEALTH INFORMATION

Our privacy officer has the overall responsibility to implement and enforce privacy policies and procedures to protect your protected health information. You can be assured that every effort is taken to comply with federal and state laws — physically, electronically and procedurally — to safeguard your information. In some situations, where state laws provide greater protection for your privacy, we will follow the provisions of that state law Blue Cross requires all of its employees, business associates (such as Prime Therapeutics), providers and vendors to adhere to federal and state privacy laws. Following are descriptions of how your protected health information is handled throughout our administration of your health plan.

Effective November 1, 2017

PERMITTED HANDLING OF PROTECTED HEALTH INFORMATION

At Blue Cross, your protected health information is handled in a number of different ways as we administer your health plan benefits. The following examples show you the various uses we are permitted by law to make without your authorization:

Treatment. We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it to aid in your treatment. We may also disclose your protected health information to these health care providers in our effort to provide you with preventive health, early detection and disease and case management programs.

Payment. To administer your health benefits, policy or contract, we must use and disclose your protected health information to determine:

- → Eligibility
- → Claims payment
- → Utilization and management of your benefits
- → Medical necessity of your treatment
- → Coordination of your care, benefits and other services
- → Responses to complaints, appeals and external review requests

We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts, provided that no genetic information may be used for underwriting purposes.

Health care operations. To perform our health plan functions, we may use and disclose your protected health information to provide programs and evaluations, such as:

- → Health improvement or health care cost-reduction programs
- → Competence or qualification reviews of health care professionals
- → Fraud and abuse detection and compliance programs
- → Quality assessment and improvement activities and outcomes evaluation

- → Performance measurement and outcome assessments, health claims analysis and health services outreach
- → Case management, disease management and care coordination services

We may also disclose your protected health information to Blue Cross affiliates and business associates (such as Delta Dental or Prime Therapeutics) that perform payment activities and conduct health care operations on our behalf.

Service reminders. We may contact you to remind you to obtain preventive health services or to inform you of treatment alternatives and/or health-related benefits and services, which may be of interest to you.

ADDITIONAL USES AND DISCLOSURES

In certain situations, the law permits us to use or disclose your protected health information without your authorization. These situations include:

Required by law. We may use or disclose your protected health information, as we are required to do so by state or federal law, including disclosures to the U.S. Department of Health and Human Services. Also, we are required to disclose your protected health information to you in accordance with the law.

Public health issues. We may disclose your protected health information to an authorized public health authority for public health activities in controlling disease, injury or disability. For example, we may disclose your protected health information to the childhood immunization registry.

Abuse or neglect. We may make disclosures to government authorities concerning abuse, neglect or domestic violence as required by law.

Health oversight activities. We may disclose your protected health information to a government agency authorized to conduct health care system or governmental procedures such as audits, examinations, investigations, inspections and licensure activity.

Legal proceedings. We may disclose your protected health information in the course of any legal proceeding, in response to a court order or administrative judge and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law enforcement. We may disclose your protected health information to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, medical examiners, funeral directors and organ donations. We may disclose your protected health information in certain instances to coroners and medical examiners during their investigations. We may also disclose protected health information to funeral directors so that they may carry out their duties. We may disclose protected health information to organizations that handle donations of organs, eyes or tissue and transplantations. For example, if you are an organ donor, we can release records to an organ donation facility.

Research. We may disclose your protected health information to researchers only if certain established measures are taken to protect your privacy. For example, we may disclose to a teaching university to conduct medical research.

To prevent a serious threat to health or safety. We may disclose your protected health information to the extent necessary to avoid a serious and imminent threat to your health or safety or to the health or safety of others.

Military activity and national security. We may disclose your protected health information to armed forces personnel under certain circumstances, and to authorized federal officials for national security and intelligence activities.

Correctional institutions. If you are an inmate, we may disclose your protected health information to your correctional facility to help provide you health care or to provide safety to you or others.

Workers' compensation. We may disclose your protected health information as required by workers' compensation laws.

Others involved in your health care. Unless you notify us in writing, we may disclose certain billing information to a family member who calls on your behalf. The kind of information we will disclose is the status of a claim, amount paid and payment date. We will not, however, disclose medical information, such as diagnosis or the name of the provider.

Your employer. If your coverage is through your employer, we may disclose information to your employer to review group claims data or to conduct an audit. All information that could be used to identify specific participants is removed unless such identification is necessary.

YOUR AUTHORIZATION

Any uses and disclosures not described in this notice, including most uses and disclosures of psychotherapy notes, the use and disclosure of protected health information for marketing purposes, and the sale of any protected health information, will require your written authorization except where permitted by law. Keep in mind that you may cancel your authorization in writing at any time.

YOUR RIGHTS

Blue Cross would like you to know that you have additional rights regarding your protected health information. Your additional rights are described below:

Your right to request restrictions. You have the right to request restrictions on the way we handle your protected health information for treatment, payment or health care operations as described in the "Permitted handling of protected health information" section of this notice. The law, however, does not require us to agree to these restrictions. If we do agree to a restriction, we will send you a written confirmation and will not use or disclose your protected health information in violation of that restriction. If we don't agree, we will notify you in writing.

Your right to confidential communications. We will make every effort to accommodate reasonable requests to communicate with you about your protected health information at an alternative location. For our records, we need your request in writing, except in emergency situations where verbal requests will be accepted. It is important that you understand that any payment or payment information may be sent to the original address in our records.

Your right to access. You have the right to receive (or request that a designated person receive), by written request, a copy of your protected health information that is contained in a "designated record set," with some specified exceptions. For example, if your doctor determines that your records are sensitive, we may not give you access to your records. You also have the right to request an electronic copy of protected health information that is maintained electronically.

What is a designated record set?
It's a group of records used to administer your health benefits, including:

- → Enrollment
- → Payment
- → Claims adjudication
- → Case or medical management records

Your right to amend your protected health information. You have the right to ask us to amend any protected health information that is contained in a "designated record set." For our records, your request for an amendment must be in writing. Blue Cross will not amend records in the following situations:

- → Blue Cross does not have the records you want amended
- → Blue Cross did not create the records that you want amended
- → Blue Cross has determined that the records are accurate and complete
- → The records have been compiled in anticipation of a civil, criminal or administrative action or proceeding
- → The records are covered by the federal Clinical Laboratory Improvement Act

If you have requested an amendment under any of these situations, we will notify you in writing that we are denying your request. You have the right to file a written statement of disagreement with us, and we have the right to rebut that statement. Please note that changes of addresses are not required in writing.

Your right to information about certain disclosures. You have the right to request (in writing) information about any times we have disclosed your protected health information for any purpose other than the following exceptions:

- → Treatment, payment, or health care operations as described in the "Permitted handling of protected health information" section of this notice
- → Disclosures that you or your personal representative have aurhorized
- → Certain other disclosures, such as disclosures for national security purposes

The requirement that we provide you with information about any times we have disclosed your protected health information applies for six years from the date of the disclosure. This applies only to disclosures made on or after April 14, 2003.

Your right to receive notifications of breaches of protected health information. In the event of any unauthorized acquisition, use or disclosure of your unsecured protected health information (a "breach"), Blue Cross will notify you of such breach, unless there is a low probability that your protected health information has been compromised.

FUTURE CHANGES

Although Blue Cross follows the privacy practices described in this notice, you should know that under certain circumstances these practices could change in the future. For example, if privacy laws change, we will change our practices to comply with the law. Should this occur:

- ➜ We will post a new notice on our website **bluecrossmn.com** by the effective date of the new notice and will also provide a copy of the new notice, or information about the new notice and how to obtain the new notice, in our next annual mailing to members
- ➜ The changes will apply to all protected health information we have in our possession, including any information created or received before we change the notice

QUESTIONS & ANSWERS

Q: Will you give my protected health information to my family or others?
A. We will share your protected health information with others only if either of these apply: 1. You are present, in person or on the telephone, and give us permission to talk to the other person, or 2. You sign an authorization form. You should know, however, that state laws do not allow us to disclose certain information about minors — even to their parents.

BlueCross BlueShield Minnesota

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Q: Who should I contact to get more information or to get an additional copy of this notice?

A: For additional information, questions about this Notice of Privacy Practices, or if you want another copy, please visit the Blue Cross website at **bluecrossmn.com**. You may also call us at **(651) 662-8000** with questions or to obtain forms.

Q: What should I do if I believe my privacy rights have been violated?
A: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may either:

1. Call us at the number listed above
2. File a written complaint with our Privacy Officer, Jane McMahon at the following address:
   Privacy Officer
   Blue Cross and Blue Shield of Minnesota
   P.O. Box 50821
   St. Paul, MN 55150-0821
3. Contact the Minnesota Department of Commerce at **(651) 296-2488**
4. Contact the Minnesota Department of Health toll free **1-800-657-3916**
5. Notify the Secretary of the U.S. Department of Health and Human Services (HHS). Send your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   233 N. Michigan Ave., Suite 240
   Chicago, IL 60601
   Voice Phone **(312) 886-2359**, toll free **1-800-368-1019** Fax **(312) 886-1807** or TTY **(312) 353-5693**.
6. Call the HHS Voice Hotline number at **1-800-368-1019**

Please be assured that we will not take retaliatory action against you if you file a complaint about our privacy practices either with us or HHS.