

For employees of:

St Olaf College

BLUE PERFORMANCE EMBEDDED HSA BLUECARD W/ RX

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

PLEASE READ YOUR BENEFIT 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.

နမူကတိကညီကိုင်ခိုး၊ တၢ်ကဟ့ၣ်နၢက့ၣ်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိ: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للتهاتف 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, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າພຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສ່ຳລັບ. 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.

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

Diné k'ehjí yánílt'i'go saad bee yát'i' éi t'áájiik'e bee níká'a'doowolgo éi ná'ahoot'i'. Kojí éi béesh bee hodíílnih áqííqéqíóáqéqéqí. TTY biniyégo éi íááji' béesh bee hodíílnih.

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

The claims administrator complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The claims administrator 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 the claims administrator.
- 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 the claims administrator 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 the claims administrator 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 the claims administrator 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 the claims administrator 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>.

CUSTOMER SERVICE

Whether it is for help with a claim or a question about your benefits, you can call your customer service telephone number or log onto the claims administrator's member website both located on the back of your ID card.

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

The customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.

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WELCOME

St. Olaf College recognizes this benefit booklet as both the plan document and Summary Plan Description for the plan. This benefit booklet provides you with the information you need to understand your health care plan. You are encouraged to take the time to review this information so you understand how your health care plan works.

This benefit booklet replaces all other certificates/benefit booklets you have received from the plan administrator before the effective date. For purposes of this benefit booklet, "you" or "your" refers to the employee named on the identification (ID) card and other covered dependents. Employee is the person for whom the employer has provided coverage. Dependent is a covered dependent of the employee.

The plan administrator has contracted with the claims administrator to provide coverage for its employees and their dependents. Terms are defined in "Terms You Should Know."

This plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use enhanced (tier 1) in-network providers. The Benefit Chart will indicate which services are provided by these providers. Enhanced (tier 1) in-network providers have a contract with the claims administrator specific to this plan and are providers that have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan to provide you quality health services at favorable prices. The plan also provides benefits for covered services you receive from standard (tier 2) in-network providers. These health care providers have entered into a specific network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, but are not enhanced (tier 1) in-network providers. In some cases, you receive a reduced level of coverage when you use these providers.

The plan also provides benefits for covered services you receive from out-of-network providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-network providers include out-of-network participating providers and nonparticipating providers. Out-of-network participating providers have a network contract with the claims administrator or the local Blue Cross and/or Blue Shield Plan but are not in-network providers because the contract is not specific to this plan. Rather, this is the claims administrator's larger open access network. Nonparticipating providers have not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan. You may pay a greater portion of your health care expenses when you use nonparticipating providers.

This benefit 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 benefit booklet carefully. If you have questions about your coverage, please contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at www.bluecrossmnonline.com.

This plan, financed and administered by St Olaf College, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the claims administrator and provides administrative services only. The claims administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have any questions on your health care plan, please contact customer service at the telephone number listed on the back of your member ID card.

MEMBER RIGHTS AND RESPONSIBILITIES

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

- be treated with respect, dignity and privacy;
- have available and accessible medically necessary and appropriate covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care provider in decisions about your treatment;
- give your health care provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the health care plan, the claims administrator and its health care providers in accordance with existing law;
- receive information about the health care plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health care plan, the claims administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the claims administrator and receive a prompt and fair review; and
- initiate a legal proceeding when experiencing a problem with the health care plan or its providers.

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

- know your health care plan benefits and requirements;
- provide, to the extent possible, information that the health care plan, the claims administrator and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your health care provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays 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.

BENEFIT OVERVIEW

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered 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.

Benefit Period

Your health care plan's benefit period is based on a plan year. The plan year is a consecutive 12-month period beginning on 09/01/2021.

During this time, 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.

Networks			
<p>Your provider directory lists network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is 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 customer service at the telephone number listed on your member ID card.</p>			
<ul style="list-style-type: none"> • Network providers - medical <ul style="list-style-type: none"> ▪ In Minnesota 	Blue Performance Regional Network Providers	Aware Network Providers	Nonparticipating Providers
<ul style="list-style-type: none"> ▪ Outside Minnesota 	BlueCard PPO Network Providers		
<ul style="list-style-type: none"> • Pharmacy network participating providers 	Select pharmacy network providers		

Benefits	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Nonparticipating Providers
Deductible (per plan year) <ul style="list-style-type: none"> • Individual • Family 	You pay \$2,800 You pay \$5,600	You pay \$3,000 You pay \$6,000	You pay \$4,000 You pay \$8,000
Deductible - Embedded If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.			

Benefits	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Nonparticipating Providers
<p>The amounts accumulated toward the deductible are applied to covered services provided by enhanced (tier 1) in-network, standard (tier 2) in-network and out-of-network providers.</p> <p>Amounts accumulated toward the standard in-network providers deductible also accumulate toward the enhanced (tier 1) in-network providers deductible. When the standard (tier 2) in-network providers deductible is satisfied, covered services from both standard (tier 2) in-network providers and enhanced (tier 1) in-network providers will be paid at the covered percentage.</p> <p>Amounts accumulated toward the out-of-network providers deductible also accumulate toward the enhanced (tier 1) in-network providers deductible. When the out-of-network providers deductible is satisfied, covered services from both out-of-network providers and enhanced (tier 1) in-network providers will be paid at the covered percentage.</p>			
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the plan year	Generally, you pay 40% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the plan year	Generally, you pay 50% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the plan year
Out-of-Pocket Limits - eligible medical services including pharmacy <ul style="list-style-type: none"> • Individual • Family 	<p>You pay \$3,500</p> <p>You pay \$7,000</p>	<p>You pay \$4,500</p> <p>You pay \$9,000</p>	<p>You pay \$6,000</p> <p>You pay \$12,000</p>
<p>Out-of-Pocket Limit - Embedded</p> <p>If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met</p>			
<p>The amounts accumulated toward the out-of-pocket limit are applied to covered services provided by enhanced (tier 1) in-network, standard in-network and out-of-network providers.</p> <p>Amounts accumulated toward the enhanced (tier 1) in-network out-of-pocket limit also accumulate toward the standard (tier 2) in-network out-of-pocket limit. When the enhanced (tier 1) in-network out-of-pocket limit is satisfied, covered services from enhanced (tier 1) in-network providers will be paid at 100% of the allowed amount.</p> <p>Amounts accumulated toward the standard (tier 2) in-network out-of-pocket limit also accumulate toward the enhanced (tier 1) in-network out-of-pocket limit. When the standard (tier 2) in-network out-of-pocket limit is satisfied, covered services from enhanced (tier 1) in-network providers and standard (tier 2) in-network providers will be paid at 100% of the allowed amount.</p> <p>Amounts accumulated toward the out-of-network out-of-pocket limit also accumulate toward the enhanced (tier 1) in-network and the standard (tier 2) in-network out-of-pocket limits. When the out-of-network out-of-pocket limit is satisfied, the claims administrator considers the enhanced (tier 1) in-network, standard (tier 2) in-network and out-of-network out-of-pocket limits satisfied and covered services from all providers will be paid at 100% of the allowed amount.</p>			
<p>Amounts accumulated toward the combined standard (tier 2) in-network and out-of-network providers out-of-pocket limit also accumulate toward the enhanced (tier 1) in-network providers out-of-pocket limit. When the combined standard (tier 2) in-network and out-of-network providers out-of-pocket limit is satisfied, covered services from standard (tier 2) in-network providers, out-of-network providers, and enhanced (tier 1) in-network providers will be paid at 100% of the allowed amount.</p>			

Benefits	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Nonparticipating Providers
Lifetime Maximum (per person) <ul style="list-style-type: none"> Assisted fertilization <ul style="list-style-type: none"> all services combined (medical and prescription drugs) Travel expenses for transplants in a Blue Distinction Center only Total benefits paid to all other providers combined 		<p>\$10,000</p> <p>\$5,000</p> <p>Not applicable</p>	

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
Prescription Drugs: <ul style="list-style-type: none"> Affordable Care Act (ACA) preventive covered prescription drugs 	Retail Pharmacy: You pay nothing 90dayRx Participating Retail Pharmacy: You pay nothing Mail Service Pharmacy: You pay nothing	You pay nothing
<ul style="list-style-type: none"> Designated preventive prescription drugs other than Affordable Care Act (ACA) preventive prescription drugs 	Retail Pharmacy: You pay nothing 90dayRx Participating Retail Pharmacy: You pay nothing Mail Service Pharmacy: You pay nothing	You pay nothing
<ul style="list-style-type: none"> GenRx Preferred generic prescription drugs 	Retail Pharmacy: You pay 20% coinsurance after deductible 90dayRx Participating Retail Pharmacy: You pay 20% coinsurance after deductible Mail Service Pharmacy: You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
<ul style="list-style-type: none"> GenRx Preferred brand prescription drugs 	Retail Pharmacy: You pay 20% coinsurance after deductible 90dayRx Participating Retail Pharmacy: You pay 20% coinsurance after deductible Mail Service Pharmacy: You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Prescription Drug Benefits	In-Network Provider	Out-of-Network Provider
<ul style="list-style-type: none"> • Non-preferred generic prescription drugs 	<p>Retail Pharmacy: You pay 20% coinsurance after deductible</p> <p>90dayRx Participating Retail Pharmacy: You pay 20% coinsurance after deductible</p> <p>Mail Service Pharmacy: You pay 20% coinsurance after deductible</p>	<p>You pay 20% coinsurance after deductible</p>
<ul style="list-style-type: none"> • Non-preferred brand prescription drugs 	<p>Retail Pharmacy: You pay 20% coinsurance after deductible</p> <p>90dayRx Participating Retail Pharmacy: You pay 20% coinsurance after deductible</p> <p>Mail Service Pharmacy: You pay 20% coinsurance after deductible</p>	<p>You pay 20% coinsurance after deductible</p>
<ul style="list-style-type: none"> • Retail Pharmacy Vaccine program <ul style="list-style-type: none"> ▪ certain eligible vaccines administered at a participating retail pharmacy 	<p>You pay nothing</p>	<p>NO COVERAGE</p>

BENEFIT CHART

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 copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Prior authorization, admission notification, or emergency admission notification are required for specific services. Please refer to "Health Care Management."

Please refer to "Not Covered" sections of the Benefit Chart and "General Exclusions" for additional information.

Benefit Descriptions

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

AMBULANCE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Emergency medically necessary and appropriate services from the place of departure to the nearest medical facility equipped to treat the condition 	You pay 20% coinsurance after enhanced (tier 1) in-network providers deductible.		
<ul style="list-style-type: none"> Non-emergency medically necessary and appropriate services from the place of departure to nearest medical facility equipped to treat the condition 	You pay 20% coinsurance after enhanced (tier 1) in-network providers deductible.		

NOTES:

- 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 service 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 service. Please refer to "Terms You Should Know" 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.
- Eligible services you receive from standard in-network or out-of-network providers apply to the enhanced in-network deductible
- Eligible services you receive from standard in-network or out-of-network providers apply to the enhanced in-network out-of-pocket limit.

NOT COVERED:

- 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. The plan 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 service 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)
- travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein
- ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support

NOT COVERED:

- transportation services, including ambulance services that are mainly for your convenience

BEHAVIORAL HEALTH MENTAL HEALTH CARE

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 use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Outpatient health care professional services including: <ul style="list-style-type: none"> ▪ office visit ▪ telemedicine services ▪ individual/group/family therapy (office/in-home mental health services) 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> ▪ all other professional services in an office or clinic ▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ neuropsychological examinations 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Outpatient hospital/outpatient behavioral health treatment facility services including: <ul style="list-style-type: none"> ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Professional health care services including: <ul style="list-style-type: none"> ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Facility health services including: <ul style="list-style-type: none"> ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based intensive outpatient programs (IOP) 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Inpatient health care professional services including: <ul style="list-style-type: none"> ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Inpatient hospital/residential behavioral health treatment facility services including: <ul style="list-style-type: none"> ▪ all eligible inpatient services ▪ emergency holds 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- 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.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- For home health related services, please refer to "Home Health Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- 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.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- 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.
- 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. Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa and delusional disorder.
- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
 - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
 - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and

NOTES:

- treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- Coverage is provided on the same basis as other benefits 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.
- Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
- 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. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; education classes for DUI or DWI offences; competency evaluations; adoption home status; parental competency; and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care and lodging programs, halfway house services, and skills training
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars
- 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 provided herein
- services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- services for therapeutic day care and therapeutic camp services
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law
- services for or related to marriage/couples counseling

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Outpatient health care professional services including: <ul style="list-style-type: none"> ▪ office visit ▪ telemedicine services ▪ individual and family therapy 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> ▪ all other professional services in an office or clinic ▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services ▪ opioid treatment 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Inpatient health care professional services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Inpatient hospital/residential behavioral health treatment facility services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
 - inpatient hospital or substance use disorder treatment facility provider services for detoxification
 - substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services
 - outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy
 - 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
 - admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold
 - coverage includes medication assisted treatment (MAT) for opioid use disorder.
- For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For home health related services, please refer to "Home Health Care."
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

NOTES:

- Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:
 - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
 - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
 - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- services for substance use disorder or addictions not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate
- evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services, and skills training
- substance use disorder 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
- 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; 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
- services for therapeutic day care and therapeutic camp services
- services for hippotherapy (equine movement therapy)
- court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law

CHIROPRACTIC CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Spinal manipulations - includes office visit 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Other chiropractic services including therapies 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits include coverage for 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.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem and chiropractor time.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- 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
- 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
- services for or related to therapeutic massage
- maintenance services
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition
- custodial care

DENTAL CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<p>This is not a dental plan. The following limited dental-related coverage is provided:</p> <ul style="list-style-type: none"> • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth (see NOTES) • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: <ul style="list-style-type: none"> ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Oral surgery and anesthesia for: <ul style="list-style-type: none"> ▪ removal of impacted teeth ▪ removal of tooth root without removal of the whole tooth • Root canal therapy • Surgical and nonsurgical treatment of Temporomandibular Joint (TMJ) disorder and craniomandibular disorder including: <ul style="list-style-type: none"> ▪ orthognathic surgery ▪ related orthodontia 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

NOTES:

- For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc.
- Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.
- Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures.
- Bone grafts for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.
- Accident-related dental services, treatment and/or restoration of a sound and healthy natural tooth must begin within six (6) months of the date of injury. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.

NOTES:

- 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 charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
- 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.

NOT COVERED:

- services for or related to orthodontia, except as provided herein
- oral surgery procedures, except as provided herein
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein
- services for or related to replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein
- services, including dental splints, to treat bruxism
- charges for routine dental care, except as provided herein

EMERGENCY CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law 	You pay 20% coinsurance after enhanced (tier 1) in-network providers deductible		
<ul style="list-style-type: none"> Outpatient hospital/facility services to treat an emergency medical condition as defined in Minnesota law 	You pay 20% coinsurance after enhanced (tier 1) in-network providers deductible		

NOTES:

- In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a medical emergency the claims administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day. Once the crisis has passed, call your physician to receive appropriate follow-up care.
- Please refer to "Terms You Should Know" for a definition of medical emergency.
- For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
- For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
- Eligible services you receive from standard in-network or out-of-network providers apply to the enhanced in-network deductible.
- Eligible services you receive from standard in-network or out-of-network providers apply to the enhanced in-network out-of-pocket limit.

GENDER CONFIRMATION CARE

The services outlined on this page are for the treatment of gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. The therapeutic approach to gender dysphoria, as outlined by the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, from the World Professional Association for Transgender Health (WPATH), may consist of several interventions with the type and sequence of interventions differing from person to person.

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Outpatient health care professional services including: <ul style="list-style-type: none"> ▪ office visit 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Professional services for gender affirming procedures for the treatment of gender dysphoria 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Services include related preparation and follow-up treatment care.
- For outpatient counseling services, please refer to "Behavioral Health Mental Health Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For prescription drugs for the management of gender dysphoria, please refer to "Prescription Drugs."
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
- For more information contact customer service at the telephone number on the back of your member ID card or visit www.bluecrossmnonline.com.
- Coverage includes cosmetic surgery related to sex transformation surgery only.

NOT COVERED:

- treatment, services or supplies that are not medically necessary and appropriate

HOME HEALTH CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Home health care agency or hospital program for home health care including, but not limited to: <ul style="list-style-type: none"> ▪ intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

NOTES:

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

NOT COVERED:

- homemaker services
- maintenance services
- services for dialysis treatment you receive from a home health care agency
- services for custodial care you receive from a home health care agency
- services for food or home-delivered meals you receive from a home health care agency
- services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury (please refer to "Custodial Care" and "Skilled Care" in the "Terms You Should Know")
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care, except as required by Minnesota law

HOSPICE CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Hospice care for terminal condition 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	NO COVERAGE

NOTES:

- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- 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.
- Inpatient respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program.
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition.
- Medical care services unrelated to the terminal condition under the hospice program are covered, but are separate from the hospice benefit.

NOT COVERED:

- services for respite care, except as provided herein
- room and board expenses in a residential hospice facility
- services for dialysis treatment you receive from hospice or a hospital program for hospice care
- services for custodial care you receive from hospice or a hospital program for hospice care
- services for food or home-delivered meals you receive from hospice or a hospital program for hospice care
- services you receive from an out-of-network provider

HOSPITAL INPATIENT CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Hospital room and board, and general nursing services • 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 • Use of operating, delivery, and treatment rooms and equipment • 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 • Prescription drugs and medicines provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Telemedicine services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

NOTES:

- The health care plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major organ transplant or other kinds of transplants, please refer to "Transplant."

NOTES:

- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
 - potential donor testing;
 - donor evaluation and work-up; and
 - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
 - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
 - diagnostic pathology consisting of laboratory and pathology tests;
 - diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
 - allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- The health care plan covers anesthesia and inpatient hospital services 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

NOT COVERED:

- charges for inpatient admissions which are primarily for diagnostic studies
- personal comfort items such as telephone, television
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- communication services provided on an outpatient basis or in the home
- services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care, except as required by Minnesota law

HOSPITAL OUTPATIENT CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Outpatient hospital/facility services, except as noted below • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs and medicines provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility. 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Laboratory services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Diagnostic imaging services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Facility billed freestanding ambulatory surgical center services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Urgent care center visits <ul style="list-style-type: none"> ▪ facility billed services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> ▪ Facility laboratory services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> ▪ Facility diagnostic imaging services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Pre-admission testing is covered for 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.
- Coverage is provided for 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.
- Coverage is provided for anesthesia, anesthesia supplies and devices 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.
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The health care plan covers anesthesia and outpatient hospital services 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.
- Assisted fertilization services are subject to a lifetime maximum limit of \$10,000 per person for medical services and prescription drugs combined.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

INFUSION THERAPY

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

NOTES:

- Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting.
- Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

NOT COVERED:

- home/suite infusion services or supplies not specifically listed as covered services
- nursing services to administer home/suite infusion therapy when the patient or caregiver can be successfully trained to administer therapy

MATERNITY CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Prenatal hospital/facility provider services 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Prenatal professional services 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Health care professional services for: <ul style="list-style-type: none"> delivery in a hospital/facility examination of the newborn infant while the mother is an inpatient 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> <ul style="list-style-type: none"> postpartum care <ul style="list-style-type: none"> office visit 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> all other eligible services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Inpatient hospital/facility services for: <ul style="list-style-type: none"> delivery in a hospital/facility postpartum care 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> <ul style="list-style-type: none"> postpartum care 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- 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.
- If you think you are pregnant, you may contact your physician or go to an in-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.
- Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
- Hospital, medical and surgical services rendered by a facility provider or professional provider for:
 - Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

NOTES:

- Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes 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.
- Under federal law, group health plans such as this plan are required to provide benefits for any hospital length of stay in connection with childbirth as follows:
 - inpatient hospital coverage for the mother (to the extent the mother is 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. Please refer to "Home Health Care."
 - inpatient hospital coverage for the newborn (to the extent the newborn is 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 plan. Please 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.

NOT COVERED:

- health care professional services for childbirth deliveries in the home
- services for or related adoption fees
- services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted fertilization, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan
- services for childbirth classes
- services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue
- services for donor ova or sperm
- services for or related to elective cesarean (C)-section for the purpose of convenience
- services and prescription drugs for or related to the selection of gender in embryos

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Durable medical equipment (DME), except as noted below • Amino acid-based elemental formula • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Scalp hair prostheses (wigs) for hair loss due to alopecia areata due to only • 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 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Insulin infusion devices 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Blood glucose monitors 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Electric breast pump 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Cochlear implants 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> • Non-investigative bone conductive hearing devices 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes the 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.
- 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:

NOTES:

- 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.
- The rental or, upon approval by the claims administrator, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a health care provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.
- 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®, Alfamino, and E028 Neocate Splash.
- Coverage for eligible orthotic devices includes 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.
- Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per person per plan year.
- Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
- 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.
- You are required to obtain prior authorization for durable medical equipment when you use nonparticipating providers in Minnesota or any provider outside of Minnesota. Please refer to www.bluecrossmnonline.com (click on "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources") or contact customer service at the telephone number on the back of your member ID card.

NOT COVERED:

- foot orthoses, except as provided herein
- services for or related to hearing aids or devices, except as provided herein
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary and appropriate for durable medical equipment, supplies, and prosthetics
- 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
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- replacement of properly functioning durable medical equipment
- duplicate equipment, prosthetics, or supplies
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- charges for devices for maintenance services
- scalp hair prostheses (wigs), except as provided herein
- charges for the rental of a manual breast pump
- 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)

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Physician office visits 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Specialty physician office visits 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> E-visits Telephone consultations 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Urgent care center visits for illness/injury <ul style="list-style-type: none"> office visit for urgent care professional laboratory services for urgent care professional diagnostic imaging services for urgent care all other professional services for urgent care 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Retail health clinic <ul style="list-style-type: none"> retail health clinic office visit laboratory services all other professional services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Professional office laboratory services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Professional outpatient laboratory services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Professional office diagnostic imaging services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Professional outpatient diagnostic imaging services 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Professional billed services received at a freestanding ambulatory surgical center 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Assisted Fertilization 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> All other professional services – office/clinic 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> All other professional services – outpatient hospital/facility 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.
 - 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.
 - 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:
 - 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.
- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
 - Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
 - The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; and psychotherapy.
- A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/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.
- The plan covers kidney and corneal transplants. For kidney transplants done in conjunction with an eligible major organ transplant, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
 - potential donor testing;
 - donor evaluation and workup; and
 - hospital and professional services related to organ procurement.
- The 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.
- Diagnostic services include the following when ordered by a health care provider:
 - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
 - diagnostic pathology consisting of laboratory and pathology tests;
 - diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the claims administrator; and
 - allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- Eligible therapeutic injections, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider and eligible under the "Office Visit and Professional Services" benefit. For injectable medications billed by a pharmacy or specialty drugs billed by the participating specialty pharmacy network provider, please refer to "Prescription Drugs." For specialty drugs that are administered in a clinic or an outpatient hospital, your health care provider may be required to obtain the specialty drugs from a designated vendor.
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The plan covers services for or related to growth hormone replacement therapy if it is determined to be medically necessary and appropriate and otherwise covered under this health care plan.
- Please refer to "Preventive Care" for female sterilization.
- You are entitled to receive care at the in-network level from out-of-network providers if these services are covered under your 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.
- 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.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member who is present and participating in the televideo visit at a remote facility.

NOTES:

- Therapeutic injections includes coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. 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.
- For self-administered prescription medications/drugs, please refer to "Prescription Drugs."
- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the medical benefit. Medical policy guidelines are available on our website at www.bluecrossmnonline.com or contact customer Service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believe that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the drug if it is a covered prescription drug under your plan.
- Assisted fertilization services are subject to a lifetime maximum limit of \$10,000 per person for medical services and prescription drugs combined.
- The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.

NOT COVERED:

- out-of-network provider-initiated communications
- charges for giving injections that can be self-administered
- self-administered drugs that are available for coverage under the pharmacy/prescription drug benefit
- services for autopsies
- services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein
- separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered under this plan
- services for or related to the LINX™ Reflux Management System (considered investigative) for the treatment of GastroEsophageal Reflux Disease (GERD)
- services and supplies for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein
- services 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
- services for educational classes or programs, except as required by law
- services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services

NOT COVERED:

- services for or related to vocational rehabilitation (defined as service 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
- 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
- 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; 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
- services for or related to reversal of sterilization

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Habilitative and rehabilitative office visits from a physical therapist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitative and rehabilitative therapies from a physical therapist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitative and rehabilitative office visits from an occupational therapist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitative and rehabilitative therapies from an occupational therapist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitative and rehabilitative office visits from a speech or language pathologist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Habilitative and rehabilitative therapies from a speech or language pathologist 	You pay 20% coinsurance after deductible	You pay 40% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes benefits for 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.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- Office visits may include an evaluation or re-evaluation of the following therapies:
 - physical
 - occupational
 - speech
 - swallowing
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

NOT COVERED:

- services for or related to vocational rehabilitation (defined as service 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
- 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

PRESCRIPTION DRUGS

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets • Prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated specialty drugs (see NOTES below) • Insulin • Affordable Care Act (ACA) preventive covered prescription drugs • FDA-approved tobacco cessation drugs and products, subject to limitations below • Designated specialty drugs purchased through a participating specialty pharmacy network supplier • Retail pharmacy vaccine program <ul style="list-style-type: none"> ▪ certain eligible vaccines administered at a participating retail pharmacy (see NOTES below) 	<p>Please refer to "Prescription Drug Benefits" in "Benefit Overview."</p>	<p>Please refer to "Prescription Drug Benefits" in "Benefit Overview."</p>	<p>Please refer to "Prescription Drug Benefits" in "Benefit Overview."</p>

NOTES:

- Covered prescription drugs include drugs listed in your health care plan's covered drug list; including compounded medications, consisting of the mixture of at least two (2) or more FDA-approved prescription drugs/medications. (Please refer to "Terms You Should Know").
- The claims administrator covered drug list is a 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. This list can change throughout the year.
- Eligible prescription drugs are covered when you purchase them through the pharmacy network applicable to your health care plan, except as provided herein. For convenience and choice, in-network pharmacies include both major chains and independent stores. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- The claims administrator 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.
- To receive a copy of your covered drug list visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.

NOTES:

- The drug list is subject to periodic review and modification by the claims administrator or a designated committee of physicians and pharmacists.
- A retail pharmacy is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible prescription drugs and diabetic supplies are generally covered up to a 31-day supply.
- 90dayRx includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy that dispenses prescription drugs through the U.S. Mail. Eligible prescription drugs are dispensed up to a 90-day authorized supply of ongoing, long-term prescription drugs.
- 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.
- Amino acid-based elemental formula is considered a supply item. Please refer to "Medical Equipment and Supplies."
- Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
- There may be circumstances where early or extended prescription drug refills are available. Please contact customer service at the telephone number listed on the back of your member ID card for further information. Restrictions apply.
- The claims administrator 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 the claims administrator and/or the health care plan and will not be considered in calculating any coinsurance, copay, deductible, or benefit maximums, except as required by law.
- Benefits are provided for a 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 Drug Benefits" in the "Benefit Overview" section for outpatient drug coverage.
- Benefits are provided for designated ACA preventive drugs with a prescription which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or ACA preventive prescription drug coverage, please visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card.
- The claims administrator applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications where a \$0 member cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If your prescribing health care professional determines that none of the \$0 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmnonline.com (select "Forms" then "Coverage Exception Form").
- Covered prescription drugs also include selected specialty prescription drugs within, but not limited to, the following prescription drugs classifications only when such prescription drugs are covered medications and are dispensed through exclusive specialty pharmacy network supplier. Specialty prescription drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty prescription drugs are prescription drugs including, but not limited to prescription drugs used for: infertility; growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and hemophilia. A current list of designated specialty prescription drugs and suppliers is available at www.bluecrossmnonline.com, or contact customer service at the telephone number listed on the back of your member ID card. Specialty prescription drugs are not available through 90dayRx.

NOTES:

- Specialty prescription drugs may be ordered by a health care provider on your behalf or you may submit the prescription order directly to the specialty pharmacy network supplier. In either situation, the specialty pharmacy network supplier will deliver the prescription to you.
- 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 or contact customer service at the telephone number listed on the back of your member ID card.
- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective 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 customer service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact customer service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the prescription drug if it is a covered prescription drug under your plan.
- If you are prescribed a Brand Drug when there is an equivalent Generic Drug, you will also pay the difference in cost between the Brand Drug and the Generic Drug, in addition to the applicable member cost-sharing. When you have reached your Out-of-Pocket Limit, you still pay the difference in cost between the Brand Drug and the Generic Drug, even though you are no longer responsible for the applicable Prescription Drug member cost-sharing. You are also responsible for the payment differential when a Generic Drug is authorized by the Physician and the member purchases a Brand Drug. Your payment is the price difference between the Brand Drug and Generic Drug in addition to the Brand Drug cost-sharing amounts that apply.
- 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.

NOT COVERED:

- any charges by any pharmacy provider or pharmacist, except as provided herein
- any prescription for more than the retail days supply or 90dayRx days supply as outlined in "Benefit Overview," except as provided herein
- charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider
- 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
- solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and as provided in the "Benefit Chart"
- investigative or non-FDA approved drugs, except as provided by law
- vitamin or dietary supplements, except as provided herein
- services for or related to tobacco cessation drugs and program fees and/or supplies, except as provided herein
- 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

NOT COVERED:

- medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. Covered medical devices are generally submitted and reimbursed under your medical benefits, please refer to “Medical Equipment and Supplies”
- specialty drugs not purchased through a specialty pharmacy network supplier
- drugs removed from the covered drug list due to safety reasons may not be covered
- over-the-counter drugs, except as provided herein
- tobacco cessation drugs and products without a prescription
- prescription drugs for the treatment of sexual dysfunction including, but not limited to erectile dysfunction
- prescription drugs for cosmetic alteration
- prescription drugs for weight loss

PREVENTIVE CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers 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, Health Resources and Services Administration (HRSA), and the Internal Revenue Service (IRS) for:			
Adults and children age 6 and older			
<ul style="list-style-type: none"> Routine physical examinations 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Diagnostic services and procedures <ul style="list-style-type: none"> surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination) 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Vision examination (glaucoma, acuity, refraction) 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Routine gynecological examinations, including a Papanicolaou (PAP) test 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Colorectal cancer screening Prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
Pediatric			
<ul style="list-style-type: none"> Routing physical examinations from birth to age 6 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible
<ul style="list-style-type: none"> Pediatric immunizations from birth to age 18 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> Diagnostic services and procedures from birth to age 6 	You pay nothing	You pay nothing	You pay 50% coinsurance after deductible

NOTES:

- Preventive care services are consistent with state and federal statutes, regulations, and related guidance.
- Routine physical examinations including a complete medical history for adults, and other items and services.
- For more information regarding preventive care services, please visit www.bluecrossmnonline.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- Pediatric preventive care services are limited to those on the health care plan's preventive schedule. Gender, age and frequency limits may apply.
- The claims administrator periodically reviews the schedule of covered services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP of the Centers for Disease Control, HRSA, and the IRS. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member website at www.bluecrossmnonline.com (choose the "Live Healthy" tab at the top, then "Preventive Care"), or contact customer service at the telephone number listed on the back of your member ID card.
- 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 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.
- 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.
- You are entitled to receive care at the in-network level for screening for sexually transmitted disease or HIV.
- Adult preventive care services are limited to those on the health care plan's preventive schedule and the women's health preventive schedule. Gender, age and frequency limits may apply.
- Pediatric preventive care services are limited to those on the health care plan's preventive schedule. Gender, age and frequency limits may apply.
- Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the USPSTF, ACIP of the Centers for Disease Control, and the HRSA. For more information regarding elective sterilization coverage, please visit www.bluecrossmnonline.com (choose "Live Healthy" then "Preventive Care") or contact customer service at the telephone number listed on the back of your member ID card.
- Benefits are provided for a 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 Drug Benefits" in the "Benefit Overview" section for outpatient drug coverage.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of USPSTF, ACIP of the Centers for Disease Control, HRSA, or the IRS recommendations and criteria may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
- All female members, regardless of age, are covered for routine gynecological examinations, including a pelvic and clinical breast examination.

NOTES:

- Benefits are provided to eligible dependent children for pediatric immunizations.
- 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.

NOT COVERED:

- services 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

RECONSTRUCTIVE SURGERY

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part • 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. • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: <ul style="list-style-type: none"> ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Elimination or maximum feasible treatment of port wine stains 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

NOTES:

- If more than one (1) surgical procedure is performed during the same operative session, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Congenital means present at birth.
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

NOT COVERED:

- repairs of scars and blemishes on skin surfaces
- oral surgery procedures, except as provided herein
- dentures, regardless of the cause or condition, and any associated services including bone grafts
- dental implants, and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19

SKILLED NURSING FACILITY CARE

The Plan Covers:	Enhanced (Tier 1) In-Network Providers	Standard (Tier 2) In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy 	<p>You pay 20% coinsurance after deductible</p>	<p>You pay 40% coinsurance after deductible</p>	<p>You pay 50% coinsurance after deductible</p>

<p>NOT COVERED:</p> <ul style="list-style-type: none"> • custodial care, nonskilled care, adult daycare or personal care attendants • services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care • services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience • treatment, services or supplies that are not medically necessary and appropriate • services for or related to skilled nursing care - extended hours, also referred to as private-duty nursing care, except as required by Minnesota law

TRANSPLANT

The Plan Covers:	Blue Distinction Centers for Transplants SM (BDCT) Providers	Participating Transplant Providers	Nonparticipating Transplant Providers
<ul style="list-style-type: none"> • Benefits may be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of the following: medically necessary and appropriate human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: <ul style="list-style-type: none"> ▪ allogeneic and syngeneic bone marrow transplant and peripheral 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 <ul style="list-style-type: none"> • Pancreas Transplant Alone (PTA) • Simultaneous Pancreas-Kidney (SPK) transplant • Pancreas After Kidney (PAK) transplant ▪ small-bowel and small-bowel/liver 	<p>You pay nothing of the Transplant Payment Allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider</p> <p><u>Travel expenses related to an eligible transplant at a (BDCT) Designated Transplant Provider only:</u></p> <p>You pay 20% coinsurance after deductible up to a Lifetime Maximum benefit of \$5,000 per member.</p>	<p>You pay 50% coinsurance after deductible and \$5,000 transplant specific copay when you use a participating transplant provider.</p>	<p>NO COVERAGE</p>

NOTES:

- Transplant specific copayments do not apply to the out-of-pocket limits.
- For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the claims administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.

NOTES:

- Kidney transplants when not done in conjunction with an eligible major organ transplant noted above, and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Office Visit and Professional Services," etc.
- 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.
- For services not included in the transplant payment allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures, and should be submitted in writing or faxed to 651-662-1624.
- 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.
- 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.

NOT COVERED:

- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- 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
- living donor organ and/or tissue transplants, except as provided herein
- benefits for travel expenses when you are using a Non-BDCT provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- transplant services you receive from a nonparticipating provider

GENERAL EXCLUSIONS

Except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "NOT COVERED" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Court-ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as provided under Minnesota law.
2. Custodial care, nonskilled care, adult daycare or personal care attendants.
3. Services rendered prior to your effective date of coverage.
4. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
5. Treatments, services or supplies which are not medically necessary and appropriate based on the definition of "Medically Necessary and Appropriate" in "Terms You Should Know."
6. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
7. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
8. Services for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
9. Services for or related to hearing aid devices and tinnitus maskers for adults age 19 and older.
10. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, except when medically necessary and appropriate and provided by an eligible health care provider.
11. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the claims administrator and deemed eligible for coverage.
12. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health care plan and you elect this coverage as primary.
13. 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.
14. Charges for the covered patient's failure to keep a scheduled visit.
15. Charges billed by your provider for the completion of a claim form.
16. Any other medical or dental service or treatment or prescription drug, except as provided herein.
17. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
18. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
19. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.

20. Services which are not prescribed by or performed by or upon the direction of a professional provider.
21. Services rendered by other than ancillary providers, facility providers or professional providers.
22. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
23. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat the member's illness, injury, or disease.
24. Services rendered by a provider who is a member of your immediate family.
25. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
26. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
27. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
28. Tobacco cessation drugs and products without a prescription.
29. Services incurred after the date of termination of your coverage, except as provided herein.
30. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
31. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
32. Services that are provided without charge, including services of the clergy.
33. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
34. Services for or related to acupuncture, except for medically necessary and appropriate acupuncture services for the treatment of chronic pain (defined as a duration of six (6) months); and for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy, except as provided herein.
35. 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.
36. Services for dependents if you have employee-only coverage.
37. Services that are not within the scope of licensure or certification of a provider.
38. Services that are prohibited by law or regulation.
39. Services for furnishing medical records or reports and associated delivery services.
40. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.
41. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.
42. Services for or related to therapeutic massage.
43. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm.
44. Charges for donor ova or sperm.
45. 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.

46. 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.
47. 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; 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.
48. Services and fees for or related to health clubs and spas.
49. Services for or related to the repair of scars and blemishes on skin surfaces.
50. Services for hippotherapy (equine movement therapy).
51. Maintenance services.
52. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
53. Services for educational classes or programs, except as required by law.
54. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
55. Services for or related to gene therapy (for those considered experimental) as a treatment for inherited or acquired disorders.
56. 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.
57. Charges for growth hormone replacement therapy, except for services that meet medical necessity and appropriateness criteria.
58. Services for or related to fetal tissue transplantation.

In addition, under your prescription drug benefits, except as specifically provided in this health care plan or as the claims administrator is mandated or required to provide based on state or federal law, no benefits will be provided for:

59. Charges for Prescription Drugs dispensed for Treatment of an Illness or an injury for which the group is required by law to furnish Hospital care in whole or in part—including, but not limited to state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
60. Charges for Prescription Drugs to which you are entitled, with or without charge, under a Plan or program of any government or governmental body.
61. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
62. Charges for over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to "Prescription Drugs" for more information.
63. Charges for food supplements.
64. Charges for any drugs prescribed for cosmetic purposes only.
65. Charges for any drugs which are investigative.
66. Prescription drugs, including but not limited to biological products, biosimilars, and gene or cell therapies, that have an alternative drug available similar in safety and effectiveness and is more cost-effective.
67. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
68. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
69. Over-the-counter drugs, except as provided herein.

HEALTH CARE MANAGEMENT

Medical and Behavioral Health Care Management

The claims administrator reviews services to verify that they are medically necessary and appropriate and that the treatment provided is the proper level of care. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization or admission notification, or emergency admission notification.

Prior authorization and admission notification are required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, no later than two (2) business days, following the admission.

Prior Authorization

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

Participating Providers in Minnesota and Bordering Counties

For services that require prior authorization participating providers in Minnesota and bordering counties are required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. 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. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges.

The claims administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The claims administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The claims administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The claims administrator will use an expedited review process 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, the claims administrator 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. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The claims administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, inform the claims administrator that you will be admitted for inpatient hospitalization or post-acute care services (e.g., long-term acute care, acute rehabilitation, skilled nursing facility, residential treatment or half-way house). The claims administrator requires that you, or your provider, as determined below, call us prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency admission notification** is a process whereby the provider, or you, inform the claims administrator of an unplanned or emergency admission, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, when required, the claims administrator will provide a review of medical necessity and appropriateness related to a specific request for care or services. As needed during an admission, the claims administrator will review the continued stay to determine medical necessity and appropriateness and to help you when you are discharged

You, or your provider, may also be required to obtain prior authorization for the services or procedures done during a hospital stay; for example, an elective surgery that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the claims administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card. They will direct your call.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary and appropriate, you are liable for all the charges.

Medical and Behavioral Health Care Management Overview

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

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.

Participating Provider Outside of Minnesota/ Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 working days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

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 three (3) levels of health care services: **enhanced in-network**, **standard in-network** or **out-of-network**.

This Plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use enhanced (tier 1) in-network providers. The Benefit Chart will indicate which services are provided by these providers. Enhanced (tier 1) in-network providers have a contract with the claims administrator specific to this plan and are providers that have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan to provide you quality health services at favorable prices. The plan also provides benefits for covered services you receive from standard (tier 2) in-network providers. These health care providers have entered into a specific network contract with the claims administrator or the local Blue Cross and/or Blue Shield Plan, but are not enhanced (tier 1) in-network providers. In some cases, you receive a reduced level of coverage when you use these providers.

The Plan also provides benefits for covered services you receive from out-of-network providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers include out-of-network participating providers and nonparticipating providers. Out-of-network participating providers have a network contract with the claims administrator or the local Blue Cross and/or Blue Shield Plan but are not in-network providers because the contract is not specific to this plan. Rather, this is the claims administrator's larger open access network. Nonparticipating providers have not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield Plan. You may pay a greater portion of your health care expenses when you use nonparticipating providers.

Network Care

Network care is care you receive from providers in the health care plan's enhanced in-network or standard in-network.

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

When you receive health care within the standard in-network, in most cases you receive a reduced level of coverage than if you used enhanced in-network providers. You present your member ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the enhanced in-network or standard in-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, prior authorization may be required from the claims administrator before services are received. For specific details, please refer to "Health Care Management."

You may be responsible for paying any difference between the provider's actual charge and the claims administrator's payment.

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

Please note that you may incur significantly higher financial liability when you use out-of-network providers compared to the cost of receiving care from enhanced in-network or standard in-network providers. If you receive services from out-of-network providers, you may be responsible for any deductibles or coinsurance plus the DIFFERENCE between what the claims administrator would reimburse for the out-of-network provider and the actual charges the out-of-network provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the claims administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

Out-of-Area Care

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

Services received from providers across the country who are part of the local Blue Cross and Blue Shield PPO network (BlueCardPPO national 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 PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield PPO network. If the treatment results in an admission, the local Blue Cross and Blue Shield PPO network provider must obtain prior authorization from the claims administrator. However, it is important that you confirm the claims administrator's determination of medical necessity and appropriateness. If the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, please refer to "Health Care Management."
- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

General Provider Payment Methods

Participating Providers

Several industry-standard methods are used to pay health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health care plan, a participating provider may be an in-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. Please refer to "How Your Program Works" for additional detail on covered services received in the in-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 person 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 person per plan year for certain categories of outpatient services.

Special Incentive Payments

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

Pharmacy Payment

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

- the average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
- the pharmacy's retail price;
- the maximum allowable cost the claims administrator determines by comparing market prices (for generic drugs only); or,
- the amount of the pharmacy's billed charge.

Nonparticipating Providers

Nonparticipating providers are not network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. Please refer to "How Your Program Works" for additional detail on covered services received in the in-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 the claims administrators' 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 on: provider reimbursement databases, median costs from a

benchmark of claims, or fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than 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 the claims administrator. The allowed amount for a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the health care plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "Claims Procedures," "Claims Payment." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

In determining the allowed amount for nonparticipating providers, the claims administrator makes no representations that the allowed amount is a usual, customary or reasonable charge from a provider. Please refer to "Allowed Amount" under "Terms You Should Know" for a more complete description of how payments will be calculated for services provided by nonparticipating providers.

Example

The following table illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health care plan covers 80% for participating providers and 60% for nonparticipating providers. It also presumes that the allowed amount for a nonparticipating provider will be less than for a participating provider. The difference in the allowed amount between a Participating and nonparticipating provider could be more or less than the 20% difference in the example below.

	Participating Provider	Nonparticipating Provider
Provider charge:	\$150	\$150
Allowed amount:	\$100	\$80
Claims administrator pays:	80% (\$80)	60% (\$48)
Coinsurance you owe:	20% (\$20)	40% (\$32)
Difference up to billed charge you owe:	None	\$70 (\$150 minus \$80)
You pay:	\$20	\$102

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (e.g., anesthesiologists) or independent laboratory 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 laboratory 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 nonparticipating provider's services, you should submit the bill to the claims administrator for processing. If you have questions, please contact customer service at the telephone number listed on the back of your member ID card. 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, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the claims administrator's medical policy and/or federal law.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

When you receive care outside of the claims administrator's service area, you will receive it from one of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The claims administrator explains below how the claims administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through inter-plan arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the plan administrator to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the claims administrator will remain responsible for doing what the claims administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the claims administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or,
- the negotiated price that the Host Blue makes available to the claims administrator.

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

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

Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the claims administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If the claims administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the claims administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

Member Liability Calculation

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

Blue Cross Blue Shield Global® Core

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

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services. **You must contact the claims administrator to obtain admission notification for non-emergency inpatient services.**

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the claims administrator, the service center or online at

www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Out-of-Country Benefits

Eligible services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the standard (tier 2) in-network level of coverage.

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

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

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

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. Your Enhanced In-network providers are Blue Performance Regional providers. Your standard in-network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the Aware network and BlueCard PPO network.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

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

Please note that while you or a family member can use the services of any in-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 in-network care. You may want to double-check any provider recommendations to make sure the doctor or facility provider is in-network. Your provider directory lists network providers in our service area and may change from time to time, including as providers or the claims administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the claims administrator, including whether the provider is a network provider for your particular plan. Not every provider is a network provider for every plan. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Sign in" then "Find a Doctor") or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

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 contact customer service at the telephone number listed on the back of your member ID card.

In-Network Pharmacies

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

If you travel within the United States and need to refill a prescription, contact customer service at the telephone number listed on the back of your member ID card for help. They can help you find an in-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 in-network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **90dayRx:** 90dayRx Pharmacy includes 90dayRx participating retail pharmacy and Mail Order Pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing, long-term basis.
 - To utilize a 90dayRx participating retail pharmacy, verify that your pharmacy participates in the network and present your prescription for a 90-day fill of the eligible prescription medication.
 - To start using mail order pharmacy:
 - Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
 - Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling customer 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 the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you. Please refer to "Specialty Drugs" in "Terms You Should Know" for a list of the selected specialty prescription drug categories.

Continuity of Care

Continuity of Care for New Members

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

Continuation for up to 120 days if you:

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

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

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

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

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the claims administrator ends, rendering your clinic or provider out-of-network, and the termination was by the claims administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to an participating provider as required under the terms of your coverage under the health care plan. The claims administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The claims administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

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

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

Transition to In-network Providers

The claims administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the claims administrator's prior authorization requirements and 2) provide the claims administrator with necessary medical information related to your care.

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

Provider Termination for Cause

If it is known that the claims administrator has terminated its relationship with your provider for cause, the claims administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

GENERAL INFORMATION

Plan Administration

Plan Administrator

The general administration of the health care plan and the duty to carry out its provisions is vested in the employer. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the Plan Administrator generally has final authority to administer the health care Plan.

Powers and Duties of the Plan Administrator

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

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

Actions of the Plan Administrator

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

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

Nondiscrimination

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

Time Periods

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

Termination or Changes to the Plan

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

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

Funding

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

Controlling Law

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

Fraudulent Practices

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

Payments Made in Error

Payments made in error or overpayments may be recovered by the claims administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the claims administrator or the plan administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount paid to network providers, out-of-network participating providers, or nonparticipating providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers

When you use in-network providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

Out-of-Network Providers

Out-of-Network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the claims administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the claims administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the claims administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the claims administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the claims administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

Medical Policy Committee and Medical Policies

The claims administrator applies medical policies in order to determine benefits consistently for members. Internally developed policies are subject to approval by the claims administrator's Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the claims administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the claims administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical policies can be found at the member website. All medical policies are available upon request.

Who is Eligible

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

Eligible Employees

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

Spouse

Spouse, meaning:

1. Spouse to whom you are legally married.

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 who are claimed as exemptions on your Federal income tax return and whom are financially dependent upon you or your spouse.
- Children legally placed for adoption
- Legally adopted children and children for whom the employee or the employee's spouse is the child's legal guardian
- Foster children
- Children awarded coverage pursuant to an order of court

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

Disabled Dependent Children

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

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

Early Retiree Coverage

For employees who retire prior to January 1, 2018, at age 55 or older with 5 years of service, and are not yet Medicare eligible, they can continue health coverage for themselves to age 65. Additionally, spouses of early retirees prior to January 1, 2018, can continue health coverage until the earlier of 1) the spouse reaching the maximum of 10 years of early retiree continuation coverage or 2) the spouse reaches age 65, when they become eligible for Medicare. Children of early retirees prior to January 1, 2018, can continue health coverage until the earlier of 1) both parents reaching age 65 or 2) the child obtaining age 26. Additionally, employees who signed an Early Retirement Agreement prior to January 1, 2018, and have not yet retired, will remain eligible for the Early Retiree benefits (above) for themselves and/or their dependents, upon retirement.

Adding New Employees

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

Adding New Employees

1. If the plan administrator receives your application within 30 days after you become eligible, coverage for you and your eligible dependents starts the First Day of the Next Month.

Adding New Dependents

Adding a Spouse and/or Stepchildren

1. If the plan administrator receives the application within 30 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the first day of the month concurrent with or following the date of marriage.

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

1. If the plan administrator receives the application within 90 days of the date of birth or adoption, coverage for your child starts on the date of birth or adoption.
2. If coverage is sought pursuant to a child support order or other order to provide coverage, coverage may be effective as of the date of the court order.

Adding Disabled Dependents

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

1. If the plan administrator receives the application within 30 days of the date of eligibility, coverage for your disabled dependent starts on the first day of the month concurrent with or following the date of eligibility.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll the eligible employee or dependent **must notify the claims administrator within 30 days** of the triggering event, unless otherwise noted

below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
<p>Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission):</p> <ul style="list-style-type: none"> • loss of eligibility for employer-sponsored coverage • plan no longer offers benefits • termination of all employer contributions • termination of employment or reduction in hours • legal separation or divorce • loss of dependent child status • death of employee • move outside HMO or ACO service area • exceeding the plan's lifetime maximum • employer bankruptcy • COBRA exhaustion • employee becomes entitled to Medicare
<p>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.</p>
<p>Gaining or becoming a dependent due to marriage.</p>
<p>Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.</p>
<p>An individual who loses or gains eligibility for medical assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the claims administrator within 60 days.</p>
<p>Child support order or other court order to provide coverage.</p>

Changes in Membership Status

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

Leave of Absence or Layoff

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

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the health care plan terminates.
2. For you and your dependents, the Last Day of Month:
 - a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the claims administrator receives full payment when due. If the claims administrator terminates coverage for all employees in the health care plan for nonpayment of the charges, the claims administrator will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
 - b. you are no longer eligible.
 - c. you enter military service for duty lasting more than 31 days.

- d. you request that coverage be terminated.
 - e. you retire.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the Last Day of Month the employee and spouse divorce or legally separate or terminate their civil union.
 4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the Last Day of Month:
 - a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
 - b. a covered dependent is no longer eligible because the employee and civil union spouse terminate their civil union.
 - c. the dependent child reaches the dependent-child age limit.
 - d. the disabled dependent is no longer eligible.

Extension of Benefits

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

Continuation of Coverage

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

Qualifying Events

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

- Voluntary or involuntary termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment resulting in a loss of benefit eligibility status (less than 0.5 FTE)).

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

- The death of the **employee**.
- A termination of the **employee's** employment (as described above) or reduction in the **employee's** hours of employment resulting in a loss of benefit eligibility status (less than 0.5 FTE).
- Entering of decree or judgment of divorce or legal separation from the **employee**. (This includes if the **employee** terminates your coverage in anticipation of the divorce or legal separation. A later divorce or legal separation is considered a qualifying event even though you lost coverage earlier. You must notify the plan administrator within 60 days after the later divorce or legal separation and establish that your coverage was terminated in anticipation of the divorce or legal separation. Continuation coverage may be available for the period after the divorce or legal separation.)
- The **employee** becomes enrolled in Medicare.

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

- The death of the **employee**.
- The termination of the **employee's** employment (as described above) or reduction in the **employee's** hours of employment with the employer.
- Parents' divorce or legal separation.
- The **employee** becomes enrolled in Medicare.
- The dependent ceases to be a "dependent child" under this plan.

Your Notice Obligations

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

- divorce or legal separation; or,
- a dependent child no longer meets the health care plan's eligibility requirements.

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

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

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

Employer's and Plan Administrator's Notice Obligations

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

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

Election Procedures

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

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

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

How to Elect

Contact the employer to determine how to elect continuation coverage.

Type of Coverage

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

Qualified beneficiaries are provided the same rights and benefits as similarly-situated beneficiaries for whom no qualified event has occurred. If coverage is modified for similarly-situated active employees or their dependents, then continuation coverage will be modified in the same way. Examples include: 1) If the employer offers an open enrollment period that allows active employees to switch between plans without being considered late entrants, all

qualified beneficiaries on continuation are allowed to switch plans as well; and 2) If active employees are allowed to add new spouses to coverage if the application for coverage is received within 30 days of the marriage, qualified beneficiaries who get married while on continuation are afforded this same right.

Maximum Coverage Periods

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

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

36 Months. If a dependent loses coverage because of the **employee's** death, divorce, legal separation, the **employee** became enrolled in Medicare or because of a loss of dependent status under the health care plan, then the maximum coverage period (for spouse and dependent child) is three (3) years from the date of the qualifying event.

Continuation Premiums

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

Extension of Maximum Coverage Periods

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

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

Notice Obligation: For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the plan administrator of the SSA disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the **employee's** termination of employment or reduction of hours; 3) the date on which the qualified beneficiary loses (or would lose) coverage under the health care plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator. **Notice Obligation:** The qualified beneficiary must notify the plan administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the **employee's** termination of employment or reduction of hours).

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

- **Multiple Qualifying Events:** This extension is applicable when the initial qualifying event is the **employee's** termination of employment or reduction of hours and is followed, within the original 18-month period (or 29-month period if there has been a disability extension), by a second qualifying event that has a 36-month maximum coverage period (i.e., death of the **employee**, divorce, legal separation, the **employee** becoming enrolled in Medicare or a dependent child losing dependent status). The extension applies to the **employee's** dependents who are qualified beneficiaries.

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

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

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

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

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

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

- The employer no longer provides group health coverage to any of its employees.
- The premium for the qualified beneficiary's continuation coverage is not paid when due.
- After electing continuation, you or your dependents become covered under another group health plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
- If during a 29-month maximum coverage period due to disability, the SSA makes the final determination that the qualified beneficiary is no longer disabled.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered **employees** or their dependents whether or not they are on continuation coverage.
- Voluntarily canceling your continuation coverage.

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

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

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

Open Enrollment Rights and Special Enrollment Rights

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

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

If you or your dependents address changes, you *must* notify the plan administrator in writing so the plan administrator may mail you or your dependent important continuation notices and other information. Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the terms of the health care plan, you or your dependent *must* notify the plan administrator in writing. In addition, you must notify the plan administrator if a disabled **employee** or family member is no longer disabled.

Special Second Election Period

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Questions

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

Overview

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

Qualifying Event/Extension	Who May Continue	Maximum Continuation Period
Employment ends (for reasons other than gross misconduct) Reduction in hours of employment (lay-off, leave of absence, strike, lockout, change from full-time to part-time employment)	Employee and dependents	Earlier of: 1. 18 months, or 2. Enrollment date in other group coverage.
Divorce or legal separation	Ex-spouse/spouse who was covered on the day before the entry of a valid decree of dissolution or marriage and any dependent children that lose coverage	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.

Qualifying Event/Extension	Who May Continue	Maximum Continuation Period
Death of employee	Surviving spouse and dependent children	Earlier of: 1. 36 months; or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to the employee's enrollment in Medicare	All dependents	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Retirees of the employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within one (1) year of filing)	Retiree	Lifetime continuation.
	Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death.
Extensions to 18-month maximum continuation period: Disability, as determined by the Social Security Administration, of employee or dependent(s)	Disabled individual and all other covered family members	Earliest of: 1. 29 months after the employee leaves employment, or 2. Date total disability ends, or 3. Date coverage would otherwise end.

Coordination of Benefits

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

Definitions

These definitions apply only to this section.

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

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

"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 plan document that provides health care benefits.
3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

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

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

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

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

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

Order of Benefits Rules

1. General: When a claim is filed under this plan and another plan, this plan is a Secondary plan and determines benefits after the other plan, unless:
 - a. the other plan has rules coordinating its benefits with this plan's benefits; and
 - b. the other plan's rules and this plan's rules, in part 2. below, require this plan to determine benefits before the other plan.
2. Rules: This plan determines benefits using the first of the following rules that applies:
 - a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
 - b. Non-dependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
 - c. Dependent child of parents not separated or divorced: When this plan and another plan cover the same child as a dependent of different persons, called "parents":
 - 1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but,
 - 2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
 - d. Dependent child of parents divorced or separated: If two (2) or more plans cover a dependent child of divorced or separated parents, this plan determines benefits in this order:
 - 1) first, the plan of the parent with physical custody of the child;
 - 2) then, the plan that covers the spouse of the parent with physical custody of the child;
 - 3) finally, the plan that covers the parent not having physical custody of the child; or,
 - 4) in the case of joint physical custody, c. above applies.However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of

the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

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

Effect on Benefits of This Health Care Plan

When this section applies:

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

Reimbursement and Subrogation

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

The Health Care Plan's Right of Subrogation

If you or your dependents receive benefits under this plan arising out of an illness or injury for which a responsible party is or may be liable, this plan shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to Reimburse the Health Care Plan

You are obligated to reimburse the health care plan in accordance with this provision if the health care plan pays any

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

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

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

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

Complying with these obligations to reimburse the health care plan is a condition of your continued coverage and the continued coverage of your dependents.

Duty to Cooperate

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

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

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

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

You have a continuing obligation to notify the claims administrator of information about your efforts or your dependents' efforts to recover compensation.

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

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

Attorney's Fees and Other Expenses You Incur

The health care plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the health care plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you

or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the health care plan's right to reimbursement without the express written consent of the claims administrator.

The plan administrator may delegate any or all functions or decisions it may have under this Reimbursement and Subrogation section to the claims administrator.

What May Happen to Your Future Benefits

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the health care plan, the health care plan in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the health care plan's subrogation and reimbursement efforts. If the health care plan determines that you have failed to cooperate the health care plan may decline to pay for any additional care or treatment for you or your dependent(s) until the health care plan is reimbursed in accordance with the health care plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the health care plan for you and your dependents.

Interpretation

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

IDENTIFICATION (ID) CARD

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

HOW TO FILE A CLAIM

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

Types of Claims

A "claim" is any request for a plan benefit made in accordance with these claims procedures. You become a "claimant" when you make a request for a plan benefit in accordance with these claims procedures. There are four (4) types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

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

Urgent Care Claim

An "urgent care claim" is a special type of pre-service claim. An "urgent care claim" is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The claims administrator will determine whether a pre-service claim involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

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

Concurrent Care Claim

A "concurrent care claim" arises when the claims administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the claims administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the claims administrator has approved. If the plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the claims administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claim

A "post-service claim" is any request for a plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

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

Filing Claims

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for plan benefits to the claims administrator. A claimant is not responsible for submitting claims for services received from network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the claims administrator. The necessary forms may be obtained by contacting the claims administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the claims administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the claims administrator by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the claims administrator.

Post-Service Claims

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

Incorrectly Filed Claims

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

Timeframes for Deciding Claims

Urgent Care Claims

The claims administrator will decide an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The claims administrator will decide a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the claims administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Reduction or Early Termination

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

Post-Service Claims

The claims administrator will decide a post-service claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

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

Incomplete Claims

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

If a pre-service or post-service claim is incomplete, the claims administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the claims administrator. The claims administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.

Notification of Initial Benefit Decision

The claims administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The claims administrator will provide the claimant written notice of the decision on a pre-service or urgent care claim whether the decision is adverse or not. The claims administrator may provide the claimant with oral notice of an adverse benefit determination on an urgent care claim, but written notice will be furnished no later than three (3) days after the oral notice.

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The claims administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;
2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The claims administrator will give no deference to the initial benefit decision;
6. The claims administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
7. The claims administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The claims administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the claims administrator did not rely upon their advice;
9. The claims administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the claims administrator;
10. The claims administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The claims administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The claims administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the plan administrator.

Filing Appeals

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

Urgent Care Appeals

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

Timeframes for Deciding Appeals

Urgent Care Claims

The claims administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The claims administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The claims administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The claims administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

APPEAL PROCESS

Notification of Appeal Decision

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

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

Voluntary Appeals

A voluntary appeal may be available to a claimant receiving an adverse decision on a pre-service or post-service claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse pre-service or post-service claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the claims administrator. The claims administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeal process, contact the claims administrator.

External Review

Standard External Review

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

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

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

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

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

- a. your medical records;
- b. the attending health care professional's recommendation;
- c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
- d. the terms of the plan;
- e. evidence-based practice guidelines;

- f. any applicable clinical review criteria developed and used by the claims administrator; and
- g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

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

Expedited External Review

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

The IRO must consider the information or documents provided and is not bound by the claims administrator's prior determination.

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

Additional Provisions

Authorized Representative

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

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

Claims Payment

When a claimant uses network or out-of-network participating providers, the plan pays the provider. When a claimant uses a nonparticipating provider, the plan pays the claimant. A claimant may not assign his or her benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the plan pay a nonparticipating provider for covered services for a child. When the plan pays the provider at the request of the custodial parent, the plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of

Minnesota at the discretion of the claims administrator.

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

No Third Party Beneficiaries

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

Release of Records

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

Right of Examination

The claims administrator and the plan administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the claims administrator or the plan administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

PRIVACY OF PROTECTED HEALTH INFORMATION

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

Restrictions on the Use and Disclosure of Protected Health Information

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

Separation Between the Employer and the Plan

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

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

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

STATEMENT OF RIGHTS

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

Receive Information About Your Plan and Benefits

- a. Examine without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated benefit booklet. The Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the plan on the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT PLAN INFORMATION

Plan Name:	St Olaf College Health Care plan
Type of plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)
ERISA plan year:	September 1 st through August 31 st
Plan Number:	504
Funding Medium:	This plan is self-funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the claims administrator. Your contribution toward the cost of coverage under the plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The claims administrator's payment of claims is contingent upon the plan administrator continuing to provide sufficient funds for benefits.
Type of plan Administration:	Claims are administered by Blue Cross and Blue Shield of Minnesota pursuant to a contract between the plan and Blue Cross and Blue Shield of Minnesota.
Plan Sponsor:	St Olaf College 1520 St Olaf Avenue Northfield, MN 55057 (507) 786-3068
Plan Sponsor's Employer Identification Number:	41-0693979
Plan Administrator:	St Olaf College 1520 St Olaf Avenue Northfield, MN 55057 (507) 786-3068
Named Fiduciary for claims Purposes:	Blue Cross
Named Fiduciary for all other Purposes:	St Olaf College 1520 St Olaf Avenue Northfield, MN 55057 (507) 786-3068
Agent for services of Legal Process:	Vice President for Human Resources St Olaf College 1520 St Olaf Avenue Northfield, MN 55057 (507) 786-3068 Service of legal process may also be made on the plan administrator.

Plan Document:

The plan and its attachments, if any, constitute the written plan document required by ERISA §402.

TERMS YOU SHOULD KNOW

90dayRx - Participating 90dayRx retail pharmacies and mail service pharmacy used for the dispensing of a supply of long-term prescription drug refills.

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.

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

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

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 provided in "Benefit Overview." For in-network providers, the allowed amount is the negotiated amount of payment that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, rebates, prospective payments or other methods, the claims administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and the percentage of the allowed amount paid by the claims administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the claims administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The claims administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the claims administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the claims administrator's provider policy and procedure manual. As a result, the claims administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; or, (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the claims administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; or, (4) fee negotiations. The payment option selected by the claims administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the claims administrator.

Special circumstances

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

If you have questions about the benefits available for services to be provided by a nonparticipating provider, you will need to speak with your provider and you may contact customer service at the telephone number listed on the back of your member ID card for more information.

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

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

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

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

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.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cell therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

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 in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

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

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

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

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

Care/Case Management Plan- A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

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 prior authorization 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 prior authorization 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).

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the participating provider's billed charge. Because payment amounts are negotiated with in-network providers to achieve overall lower costs, the allowed amount for participating providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for participating providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.

For covered services from nonparticipating providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

Coinsurance Example:

You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over our allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges \$100 for a service, but our allowed amount is \$95, Blue Cross will pay 80% of the allowed amount (\$76). You must pay the 20% coinsurance on the Blue Cross allowed amount (\$19), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$24.

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out of pocket costs will be higher as shown in the example above.

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.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

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

Covered Drug List - The claims administrator's covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the claims administrator's Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee.

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.

Day Treatment - Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible - The 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. Please refer to "Benefit Overview" for the deductible amount. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your deductible.

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

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

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

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. 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 member-initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established member.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the claims administrator to be medically effective for the condition being treated. The claims administrator 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. The claims administrator 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 care 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. Pre-fabricated orthoses are manufactured in quantity and are not designed for a specific member. A custom-fitted orthosis is specifically made for an individual member.

Freestanding Ambulatory Surgical Center - A provider that facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by, or under the direction of, a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.

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 Orange Book, and

noted as such in the pharmacy database used by the claims administrator.

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 dietitians, 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 Care 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 in-network providers in its designated service area that require such in-network providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, 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.

In-Network - Depending on where you receive services, the in-network is designated as one of the following:

- When you receive services within the health care plan service area, the designated in-network for professional providers and facility providers is the Blue Performance Regional network.
- When you receive services within the claims administrator's service area, the designated in-network for professional providers and facility providers is the Blue Performance Regional network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-Network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, the claims administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Intensive Outpatient Programs (IOPs) - A behavioral health care service setting that provides structured, multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance use disorder treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Lifetime Maximum - The cumulative maximum payable for covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health care plans with the employer. The lifetime maximum does not include amounts which are the member's responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Mail Service Pharmacy - A pharmacy that dispenses prescription drugs through the U.S. Mail.

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.

Marital/Couples Therapy/Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

Marital/Couples Training - Services for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

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

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

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 use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into an in-network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

Out-of-Network Participating Provider - Providers who have a contract with the claims administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-Network Provider - A provider with a Blue Cross contract that is not specific to this plan; and nonparticipating providers.

Out-of-Pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a plan year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit. If applicable, the dollar amount reimbursed or paid by a coupon for specialty drugs will not count toward your out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance use disorder, or addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Outpatient Care - Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.

Palliative Care - Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Participating Pharmacy - A pharmaceutical provider that participates in a network for the dispensing of prescription drugs.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the claims administrator or the local Blue Cross and/or Blue Shield plan.

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

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

Plan - The plan of benefits established by the plan administrator.

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

Preferred Drug List - The claims administrator's preferred drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major

therapeutic category. The list was developed by the claims administrator's Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year.

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

Provider - A health care professional or facility 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 home infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

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 use disorder, 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.

Self-Administered Drugs - Medications you would normally take on your own, such as drugs you might take every day to treat high blood pressure. These are drugs that can be safely taken by mouth or administered by injection, inhaled, inserted, or applied topically and are covered under your pharmacy/prescription drug benefit. These drugs do not require direct supervision or administration by a health care provider, regardless of whether initial medical supervision or training is required.

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

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

Skilled Nursing Care - Extended Hours - Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. skilled nursing care - extended hours services provide complex, direct, skilled nursing care to develop caregiver

competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

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/facility 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/Specialty Physician - 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 Supplier - A pharmaceutical specialty provider that has an agreement with the claims administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

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 that is safe, more clinically effective, and in some cases more cost-effective before the step therapy medication will be paid under the drug benefit.

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

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

Supply - Equipment that must be medically necessary and appropriate for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:

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

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 provide real-time interaction between a distant site physician/medical practitioner and the member both of whom are not in the same location but are actively communicating through interactive audio and video channels.

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

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

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

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

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

The Blue Cross[®] and Blue Shield[®] Association is an association of independent Blue Cross and Blue Shield plans.

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

