For employees of:

County of Blue Earth Ind School Dist 77 DBA as Mankato ISD

$750 CMM Deductible Plan

Effective Date: 07/01/2026

This information is also available in other ways to people with disabilities or who need it translated into another language by calling 1-800-382-2000. For TTY call 711.

PLEASE READ YOUR BENEFIT BOOKLET CAREFULLY

BlueCross BlueShield Minnesota

Notice of Nondiscrimination and Accessibility

The claims administrator treats everyone fairly. They do not exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). The claims administrator follows federal civil rights laws and does not discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, the claims administrator can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

Need these services? Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

Discrimination is against the law.

If the claims administrator failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting the Nondiscrimination Civil Rights Coordinator:

Email: Civil.Rights.Coord@bluecrossmn.com
Telephone: 1-800-509-5312
Mail: Blue Cross and Blue Shield of Minnesota
ATTN: Civil Rights Coordinator P3-2
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at bluecrossmn.com/NDL, or from the Nondiscrimination Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services:

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

Civil rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

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ENGLISH
ATTENTION: If you speak a language other than English, language services are available free of charge. If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge. Call 1-855-903-2583 (TTY 711).

ESPAÑOL (Spanish)
ATENCIÓN: Si habla Español, puede solicitar servicios gratuitos de asistencia lingüística. Si tiene una deficiencia visual, auditiva o del habla, podemos comunicarnos de la manera que le resulte mejor a usted. Esto puede incluir el uso de intérpretes de lengua de señas, el suministro de documentos en letra grande o braille, grabaciones de audio u otras ayudas sin cargo. Llame al 1-855-903-2583 (TTY 711).

العربية (Arabic)
تنبيه: إذا كنت تتحدث العربية، يمكنك طلب خدمات المساعدة اللغوية المجانية. إذا كنت تعاني من إعاقة بصرية أو سمعية أو نطقية، يمكننا التواصل معك بالطريقة التي تناسبك. وقد يشمل ذلك استخدام مترجمين للغة الإشارة، أو توفير المستندات بحروف كبيرة أو بطريقة برايل، أو تسجيلات صوتية، أو غيرها من الوسائل المساعدة من دون مقابل. اتصل على الرقم 1-855-903-2583 (الهاتف النصي 711).

አማርኛ (Amharic)
ትኩረት ይሰጥ፡- አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እገዛ አገልግሎቶችን መጠየቅ ይችላሉ። የማየት፣ የመስማት ወይም የመናገር ችግር ካለብዎት ለእርስዎ በተሻለ በሚሠራው መንገድ መግባባት እንችላለን። ይህ ደግሞ የምልክት ቋንቋ አስተርጓሚዎችን መጠቀምን፣ በትላልቅ ህትመቶች ወይም በብሬይል የተጻፉ ሰነዶችን፣ የድምፅ ቅጂዎችን ወይም ሌሎች መርጃዎችን ያለ ክፍያ ማቅረብን ይጨምራል። 1-855-903-2583 (TTY 711) ላይ ይደውሉ።

LUS HMOOB (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob, koj tuaj yeem thov cov kev pab cuam uas pab hom lus tau dawb. Yog hais tias koj qhov muag tsis pom kev zoo, tsis hnov lus, los sis hais tsis tau lus, peb tuaj yeem sib txuas lus hauv ib txoj hau kev uas ua hauj lwm tau zoo tshaj plaws rau koj. Qhov no tej zaum yuav muaj xam nrog kev siv cov neeg txhais lus piav tes, kev muab cov ntaub ntawv luam tawm ua tus ntawv loj los sis Ua Ntawv Su Rau Cov Neeg Tsis Pom Kev Siv Tau (Braille), kev kaw ua suab lus, los sis lwm yam kev pab yam tsis tau them nqi. Hu rau 1-855-903-2583 (TTY 711).

廣東話 (Cantonese – Traditional Chinese)
請注意：如果您說 廣東話 您可要求免費語言協助服務。 如果您有視力、聽力或言語障礙，我們會以最適合您的方式與您溝通 這可能包括使用手語傳譯員、免費提供大字體或點字文件、 錄音或其他輔助工具。請致電 1-855-903-2583 聽障熱線 (TTY 711)。

简体中文 (Chinese Simplified)
注意：如果您说普通话，则可以免费申请语言协助服务。 如果您有视力、听力或语言障碍，我们可以用最适合您的方式 与您交流。这可能包括免费提供手语翻译、大字体或盲文文件、 录音或其 他辅助工具。 请致电 1-855-903-2583（文字电话 711）。

SOOMALI (Somali)
XASUUSIN: Haddii aad ku hadasho Soomali, waxaad codsan kartaa adeegyada caawimaadda luqada oo bilaash ah. Haddii aad laxaad la'aan kataahy aragga, maqalka, ama hadalka, waxaanu kugula xidhiidhi karnaa habka adiga kuugu habboon. Tan waxaa ka mid ah in aan isticmaalno turjumaanada luuqada dhegoolaha, in la bixiyo waraaqo ku qoran xarfaha waaweyn ama qoraalka indhoolayaasha, in la sameeyo cajalado la duubay, ama in la helo waxyaabo kale oo caawimaad ah oo bilaash ah. Wac 1-855-903-2583 (TTY 711).

FRANÇAIS (French)
ATTENTION : Si vous parlez Français, vous pouvez demander des services d'assistance linguistique gratuits. Si vous avez une déficience visuelle, auditive ou vocale, nous pouvons communiquer de la manière qui vous convient le mieux. Il peut s'agir d'interprètes en langue des signes, de documents en gros caractères ou en braille, d'enregistrements audio ou d'autres aides gratuites. Composez le 1-855-903-2583 (ATS 711).

ខ្មែរ (Khmer)
ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ អ្នកអាចស្នើសុំសេវាជំនួយបកប្រែភាសាដោយឥតគិតថ្លៃ។ ប្រសិនបើអ្នកមើលមិនឃើញ ស្តាប់មិនឮ ឬនិយាយមិនបាន យើងអាចប្រាស្រ័យទាក់ទងជាមួយអ្នកតាមរបៀបផ្សេងដែលមានប្រសិទ្ធភាពល្អបំផុតសម្រាប់អ្នក។ ការប្រាស្រ័យទាក់ទងនេះអាចមានដូចជាអ្នកបកប្រែភាសាសញ្ញា ការផ្តល់ឯកសារដែលបោះពុម្ពអក្សរធំៗ ឬអក្សរស្តាប ឬការថតទុកជាសំឡេង ឬជំនួយផ្សេងទៀត ដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-855-903-2583 (TTY 711)។

한국어 (Korean)
주의: 한국어를 사용하시는 경우 귀하는 무료 언어 지원 서비스를 요청하실 수 있습니다. 시각 장애, 청각 장애 또는 언어 장애가 있는 경우 저희는 귀하에게 가장 적합한 방법으로 연락을 드릴 수 있습니다. 여기에는 수화통역사 이용, 대형 활자 또는 점자로 작성된 문서 제공, 음성 녹음 또는 기타 무료 지원이 포함될 수 있습니다. 1-855-903-2583 (TTY 711) 번으로 전화하십시오.

ကညီကျိ၁် (Karen)
ဟ်သူ၎ဉ်ဟ်သး- နမ့၊်ကတိ၊ ကညီကျိ၁် နှ၎ဉ်, နဃ့ကျိ၁်ဂ့၊်ဝီတ၊်တိစ၊၊မ၊စ၊၊လ၊တလက်ဘူးလဲ သ့နှ၎ဉ်လီ၊။ နမ့၊်အိ၎ဉ်ဒီးတ၊်တလ၊တပ့ဲ၊လ၊ မဲ်တ၊်ထံ၎ဉ်, တ၊်နၢ်ဟူ, မ့တမ့၊် တ၊်စံးကတိ၊တ၊်နှ၎ဉ် ပဆဲးကျ၊ဆဲးကျိုးတ၊်လ၊ ကျဲကဲထီ၎ဉ်လိ၎်ထီ၎ဉ်အဂ့၊ကတ၊၊်လ၊နဂီ၊်သ့နှ၎ဉ်လီ၊။ တ၊်အံ၊ ပ၎ဉ်ဃုာ်ဒီး တ၊်စူးကါ နီ၊်ခိက့၊်ဂီ၊ကျိ၁်အပှ၊ကျိ၁်ထံတ၊်တဖ၎ဉ်, တ၊်ဟ့၎ဉ်လံာ်လဲ၊်တဖ၎ဉ်လ၊ အလံာ်ဖျ၊၎ဉ်ဖးဒိ၎ဉ်, မ့တမ့၊် ပှ၊မဲာ်ဘျိ၎ဉ်အလံာ်, တ၊်ကလု၊်, မ့တမ့၊် တ၊်မ၊စ၊၊ဂုၢ၊ဂ၊တဖ၎ဉ် လ၊တလက်အဘူးလဲနှ၎ဉ်လီ၊။ ကိးလီတဲစိဆူ 1-855-903-2583 (TTY 711) တက့၊်။

မြန်မာဘာသာ (Burmese)
သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊ အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို တောင်းဆိုနိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံ၊ အကြားအာရုံ သို့မဟုတ် စကားပြောခြင်း ချို့ယွင်းမှုရှိနေပါက သင့်အတွက် အသင့်လျော်ဆုံးဖြစ်မည့်နည်းလမ်းဖြင့် ကျွန်ုပ်တို့ထံသို့ ဆက်သွယ်နိုင်ပါသည်။ ၎င်းတွင် လက်ဟန်ပြဘာသာစကား စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို ပုံနှိပ်စာလုံးကြီးများ သို့မဟုတ် မျက်မမြင်စာဖြင့် ပုံပြီးပေးခြင်း၊ အသံဖမ်းယူခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပိုးပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ဆိုပါ။

OROMOO (Oromo)
Xiyyeeffannoon haa kennamu:- Oromo Afaan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenya. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireeylii, waraabbiiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.

РУССКИЙ (Russian)
ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).

ພາສາລາວ (Lao)
ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບົກຜ່ອງດ້ານສາຍຕາ, ການໄດ້ຍິນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສື່ສານດ້ວຍວິທີທີ່ເໝາະສົມກັບທ່ານທີ່ສຸດ. ອັນນີ້ອາດຈະລວມເຖິງການໃຊ້ນາຍພາສາມື, ການจัดກຽມເອກະສານເປັນໂຕພິມໃຫຍ່ ຫຼື ອັກສອນນູນ, ການບັນທึกສຽງ ຫຼື ການຊ່ວຍເຫຼືອດ້ານສື່ອື່ນໆໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໂທ 1-855-903-2583 (TTY 711).

Tagalog (Tagalog)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyo na tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).

VIETNAMESE (Vietnamese)
LƯU Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).

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Questions?

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.

Identification (ID) Card

If your card is lost, stolen, or contains inaccurate information, please contact customer service immediately at the telephone number listed on the back of your member ID card or log onto your claims administrator's member website at bluecrossmn.com.

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Welcome

This benefit booklet provides you with the information you need to understand your health plan. You are encouraged to take the time to review this information so you understand how your health 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 benefit booklet explains the health 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 bluecrossmn.com.

This plan, financed and administered by County of Blue Earth Ind School Dist 77 DBA as Mankato ISD, 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.

This plan is not subject to ERISA.

If you have any questions on your health 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 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 plan, the claims administrator and its health care providers in accordance with existing law;
- receive information about the health plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health 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 plan or its providers.

You have the responsibility as a health plan member to:

- know your health plan benefits and requirements;
- provide, to the extent possible, information that the health 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 calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

Benefit Period

Your health plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31.

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	
Your plan has a specific network of providers, which may change from time to time, including when 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 in-network for your particular plan. Not every provider is in-network for every plan. To find an in-network provider, visit bluecrossmn.com or contact customer service at the telephone number listed on the back of your member ID card.	
● In-network Providers	
■ In Minnesota	Aware® Network providers
■ Outside Minnesota	BlueCard Traditional network providers

General Provisions		
Benefits	**In-network Providers**	**Out-of-network Providers**
Primary Care Office Visit Copay	You pay $20 per visit	Not applicable
Specialty Care Office Visit Copay	You pay $20 per visit	Not applicable
Deductible		
● Individual	You pay $750	
● Family	You pay $1,500	
Deductible - Embedded If you have other family members on the plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		
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 calendar year	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 calendar year

General Provisions		
Benefits	**In-network Providers**	**Out-of-network Providers**
Out-of-pocket Limits - eligible medical services		
● Individual	You pay $2,000	
● Family	You pay $4,000	
Out-of-pocket Limit - Embedded If you have other family members on the plan, each family member must meet their own individual out-of-pocket limit until the total amount of out-of-pocket limits paid by all family members meets the overall family out-of-pocket limit.		
Lifetime Maximum (per person)		
● Travel expenses for transplants to a Blue Distinction Center only	$5,000	
● Total benefits paid to all other providers combined	Not applicable	
Annual Maximum (per person)		
● Assisted reproductive technology		
■ all services combined (medical and prescription drugs)	$10,000	

Benefit Chart

The health 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 and be in accordance with any treatment plan prescribed by your treating health care provider. 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.

Except as specifically provided in the health plan or as mandated or required to be provided based on state or federal law, no benefits will be provided for services, supplies, prescription drugs, or charges that are noted under “Not Covered” in the benefit charts or in the “General Exclusions.”

Prior authorization, admission notification, emergency admission notification, and continued stay approvals are required for specific services. Please refer to "Health Care Management." You are required to obtain prior authorization and continued stay approvals for specific services when you use nonparticipating providers in Minnesota and any provider outside of Minnesota. For more information, please call customer service at the telephone number listed on the back of your member ID card.

Benefit Descriptions

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

Ambulance

The Plan Covers:	In-network Providers	Out-of-network Providers
• Emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services
• Non-emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services

Ambulance – Notes
1. Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured: a. from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider; b. between hospitals; or c. 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.
2. 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.
3. 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.

Ambulance – Not Covered
1. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility capable of treating your condition (example: facility A is the closest medical facility capable of treating your condition but you are 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 are 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).
2. Travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein.
3. Ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support.
4. Transportation services, including ambulance services that are mainly for your convenience.
5. Transportation to a residence.
6. Conventional air services, such as commercial airlines.

Bariatric Surgery

The Plan Covers:	In-network Providers	Out-of-network Providers
● Medically necessary and appropriate inpatient hospital/facility services for bariatric surgery from admission to discharge: ■ room and board and general nursing care ■ intensive care and other special care units ■ operating, recovery, and treatment rooms ■ anesthesia ■ prescription drugs and supplies used during a covered hospital stay ■ laboratory and diagnostic imaging	**Eligible members age 18 and older:** You pay 20% coinsurance after deductible when you use Blue Distinction Centers for bariatric surgery **Eligible members age 17 and younger:** You pay 20% coinsurance after deductible when you use in-network providers	**Eligible members age 18 and older:** NO COVERAGE **Eligible members age 17 and younger:** NO COVERAGE
● Medically necessary and appropriate outpatient hospital/facility services for bariatric surgery: ■ scheduled bariatric surgery/anesthesia ■ laboratory and diagnostic imaging ■ all other eligible outpatient hospital care related to the scheduled bariatric surgery provided on the day of surgery	**Eligible members age 18 and older:** You pay 20% coinsurance after deductible when you use Blue Distinction Centers for bariatric surgery **Eligible members age 17 and younger:** You pay 20% coinsurance after deductible when you use in-network providers	**Eligible members age 18 and older:** NO COVERAGE **Eligible members age 17 and younger:** NO COVERAGE

Bariatric Surgery – Notes
1. Outpatient hospital/facilities include designated freestanding ambulatory surgery centers.

Bariatric Surgery – Not Covered
1. Services you receive from an out-of-network provider.

Behavioral Health Mental Health Care

Your mental health is just as important as your physical health. That is why your health 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:	In-network Providers	Out-of-network Providers
• Outpatient health care provider services including: ▪ office visit ▪ telehealth services ▪ individual/group/family therapy (office/in-home mental health services)	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
▪ all other professional services in an office or clinic ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay nothing	You pay 20% coinsurance after deductible
▪ all other professional services in an outpatient hospital/facility ▪ assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	You pay nothing	You pay 20% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ assessment and diagnostic services ▪ individual/group/family therapy ▪ crisis evaluations ▪ observation beds	You pay nothing after in-network outpatient hospital/facility provider $20 copay	You pay 20% coinsurance after deductible
• Professional health care services including: ▪ clinic-based partial programs ▪ clinic-based day treatment ▪ clinic-based Intensive Outpatient Programs (IOP)	You pay nothing after in-network outpatient hospital/facility provider $20 copay	You pay 20% coinsurance after deductible
• Facility health services including: ▪ hospital-based partial programs ▪ hospital-based day treatment ▪ hospital-based Intensive Outpatient Programs (IOP)	You pay nothing after in-network outpatient hospital/facility provider $20 copay	You pay 20% coinsurance after deductible
• Inpatient health care provider services including: ▪ 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 20% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Behavioral Health Mental Health Care – Notes
1. For home health related services, please refer to "Home Health Care."
2. For laboratory and diagnostic imaging services billed by a health care provider, 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."
3. Coverage is provided for crisis evaluations delivered by mobile crisis units.
4. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a licensed psychiatrist or a doctoral level licensed psychologist, is deemed medically necessary and appropriate.
5. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation by a licensed psychiatrist or doctoral level licensed psychologist 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 plan.
6. Outpatient family therapy is covered if rendered by a health care provider and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
7. Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
8. 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.
9. Coverage is provided for medical nutrition therapy and nutritional counseling.
10. Coverage is provided for inpatient care and outpatient care for the treatment of mental illness. A 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.
11. 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.
12. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity with respect to mental health and substance use disorder treatment. Generally, this law provides that: a. mental health and substance use disorder services are to be covered on the same basis as similar medical services; b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
13. 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. An emotionally disabled child is defined as a person whose condition meets the following criteria: a. an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the state commissioner of human services; and b. seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.
14. 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 health care provider and include, but are not limited to: antibiotics, drugs and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Behavioral Health Mental Health Care – Notes
15. Benefits are provided for intensive behavioral therapy programs including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Applied Behavioral Analysis (ABA), Intensive Behavioral Intervention (IBI), and Lovaas Therapy for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or its successor.
16. The plan covers telehealth services.
17. Coverage is provided for outpatient Certified Peer Specialist and Certified Family Specialist services (also known as peer support services).

Behavioral Health Mental Health Care – Not Covered
1. Services related to 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)*.
2. Custodial care.
3. 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; educational classes for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) offences; competency evaluations; adoption home status; parental competency; and domestic violence programs.
4. Services or room and board for foster care, group homes, shelter care and lodging programs, and halfway house services.
5. Services for skills training.
6. 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).
7. Services for therapeutic day care and therapeutic camp services.
8. Services for or related to marriage/couples counseling.

Behavioral Health Substance Use Care

The Plan Covers:	In-network Providers	Out-of-network Providers
● Outpatient health care provider services including: ■ office visit ■ telehealth services ■ individual/group/family therapy	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
■ all other professional services in an office or clinic ■ assessment and diagnostic services ■ opioid treatment, including Medication Assisted Treatment (MAT)	You pay nothing	You pay 20% coinsurance after deductible
■ all other professional services in an outpatient hospital/facility ■ assessment and diagnostic services ■ opioid treatment, including Medication Assisted Treatment (MAT)	You pay nothing after in-network outpatient hospital/facility provider $20 copay	You pay 20% coinsurance after deductible
● Outpatient hospital/outpatient behavioral health treatment facility services including: ■ Intensive Outpatient Programs (IOP) and related aftercare services ■ partial hospitalization	You pay nothing after in-network outpatient hospital/facility provider $20 copay	You pay 20% coinsurance after deductible
● Inpatient health care provider services	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
● Inpatient hospital/facility services ● Residential behavioral health treatment facility services	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Behavioral Health Substance Use Care – Notes

1. Outpatient family therapy is covered if rendered by a health care provider, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.

2. Benefits provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
   a. inpatient hospital or substance use disorder treatment facility provider services for detoxification;
   b. substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services;
   c. outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy;
   d. 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;
   e. admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold; and
   f. coverage includes Medication Assisted Treatment (MAT) for opioid use disorder.

3. 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.

4. For laboratory and diagnostic imaging services billed by a health care provider, 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."

Behavioral Health Substance Use Care – Notes
5. For home health related services, please refer to "Home Health Care."
6. For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
7. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity with respect to mental health and substance use disorder treatment. Generally, this law provides that: a. mental health and substance use disorder services are to be covered on the same basis as similar medical services; b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
8. The plan covers telehealth services.
9. Coverage is provided for outpatient Certified Peer Recovery and Certified Family Specialist services (also known as peer support services).

Behavioral Health Substance Use Care – Not Covered
1. Services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
2. Custodial care.
3. Services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate.
4. 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; educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs.
5. Services or room and board for foster care, group homes, shelter care, and lodging programs, and halfway house services.
6. Services for skills training.
7. 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.
8. Services for therapeutic day care and therapeutic camp services.
9. Services for hippotherapy (equine movement therapy).

Chiropractic Care

The Plan Covers:	In-network Providers	Out-of-network Providers
● Spinal manipulations - including office visit	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● Other chiropractic services including therapies	You pay nothing after $20 copay	You pay 20% coinsurance after deductible
● Acupuncture services that are medically necessary and appropriate	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Chiropractic Care – Notes
1. 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.
2. For laboratory and diagnostic imaging services billed by a health care provider, 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."
3. An office visit copay will be applied to the office visit, evaluation, or manipulation, not to exceed one (1) copay per visit.
4. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.

Chiropractic Care – Not Covered
1. 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.
2. Services for or related to therapeutic massage.
3. Maintenance services.
4. 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.
5. Custodial care.

Dental Care

The Plan Covers:	In-network Providers	Out-of-network Providers
This is not a dental plan. The following limited dental-related coverage is provided: ● Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth ● Treatment of cleft lip and palate including: ■ dental implants ■ removal of impacted teeth or tooth extractions ■ related orthodontia ■ related oral surgery ■ bone grafts ● Diagnostic evaluation, surgical and nonsurgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD) including: ■ orthognathic surgery ■ related orthodontia	You pay nothing after office visit $20 copay for the office visit charge; you pay nothing for all other eligible services	You pay 20% coinsurance after deductible

Dental Care – Notes
1. For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc.
2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
3. Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures.
4. Bone grafts (the building up of bone in the upper or lower jaw) 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.
5. Sound natural teeth means teeth and tissue that are viable, functional and free of disease. A sound natural tooth: a. has no decay, b. has no filling on more than two (2) surfaces, c. does not have bone loss of more than 50%, d. has not had a root canal procedure (removing the tissue inside the tooth root), and e. has not been replaced by any artificial means (for example, implants, fixed or removable bridges, dentures, dental appliance, or crowns).
6. Accident-related dental services, treatment and/or restoration of a sound natural tooth must begin within 12 months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound natural teeth, crowns, fillings and bridges.
7. The health plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
8. Services for diagnostic evaluation, surgical and nonsurgical treatment of temporomandibular 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.

Dental Care – Not Covered
1. Services for or related to orthodontia, except as provided herein.
2. Oral surgery procedures, except as provided herein.
3. Services for or related to treatment of cracked or broken teeth due to biting or chewing.
4. Dentures, regardless of the cause or the condition, and any associated services including bone grafts.
5. Dental implants and associated services, except when related to services for cleft lip and palate.
6. 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.
7. Services for or related to replacement of a damaged dental bridge from an accident-related injury.
8. Osteotomies (cutting of the bone), osteoplasty (building up the bone), and other procedures associated with the fitting of dentures or dental implants, except as provided herein.
9. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein.
10. Services to treat bruxism (excessive grinding of teeth or clenching of the jaw), including dental splints.
11. Charges for routine dental care, except as provided herein.
12. Services for or related to gingival and periodontal (the gums and bone that surround and support the teeth) procedures.

Emergency Care

The Plan Covers:	In-network Providers	Out-of-network Providers
● Outpatient health care provider services to treat an emergency medical condition	You pay 20% coinsurance after deductible	Same as in-network services
● Outpatient hospital/facility services to treat an emergency medical condition	You pay 20% coinsurance after deductible	Same as in-network services

Emergency Care – Notes
1. 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. Coverage is not based only on your diagnosis, when determining if a situation is a medical emergency. The claims administrator will consider 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.
2. For follow up care, please refer to "Hospital Outpatient Care," "Hospital Inpatient Care" and "Office Visit and Professional Services."
3. If the care you receive is due to a medical emergency, prior authorization is not required.
4. Please refer to "Terms You Should Know" for a definition of medical emergency.
5. For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
6. For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."

Gender Affirming Care

The claims administrator is committed to supporting transgender and gender diverse individuals in receiving medically necessary and appropriate gender affirming healthcare as outlined in the Standards of Care for the Health of Transgender and Gender Diverse People, from the World Professional Association for Transgender Health (WPATH).

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient health care provider services including: ▪ office visit	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
• Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Gender Affirming Care – Notes
1. Gender affirming care includes, but is not limited to, breast/chest procedures, genital procedures, facial procedures, thyroid cartilage reduction, voice therapy, voice surgery, hair removal, and hormone therapy. These services are covered when they are medically necessary and appropriate for the treatment of gender dysphoria.
2. Services include related preparation and follow-up care.
3. Gender-specific preventive services are covered for transgender individuals appropriate to their anatomy. For preventive care services, please refer to "Preventive Care."
4. For outpatient counseling services, please refer to "Behavioral Health Mental Health Care."
5. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
6. For laboratory and diagnostic imaging services billed by a health care provider, 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."
7. For drugs administered by a health care provider, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
8. For more information contact customer service at the telephone number on the back of your member ID card or visit bluecrossmn.com.

Home Health Care

The Plan Covers:	In-network Providers	Out-of-network Providers
● Skilled care and other home care services ordered by a physician and provided by employees of an approved home health agency including, but not limited to: ■ intermittent skilled nursing care in your home by a: ● 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 dietitian ■ 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 covered services ■ use of appliances that are owned or rented by the home health agency ■ home health care following early maternity discharge ■ palliative care	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Home Health Care – Notes
1. Intermittent skilled nursing care consists of up to two (2) consecutive hours of care per date of service in the member's home.
2. Extended hours skilled nursing care (also known as private-duty nursing) consists of greater than two (2) consecutive hours of care per date of service in the member's home. Extended hours skilled nursing care services provide complex, direct skilled nursing care to develop caregiver competencies through training and education to optimize the member's 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.
3. Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services.
4. Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy."
5. For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
6. 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 – Notes
7. 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 birthing member/mother and newborn child.

Home Health Care – Not Covered
1. Homemaker services.
2. Maintenance services.
3. Services for dialysis treatment you receive from a home health agency.
4. Custodial care.
5. Services for food or home-delivered meals you receive from a home health agency.
6. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospice Care

The Plan Covers:	In-network Providers	Out-of-network Providers
● Hospice care for terminal condition	You pay nothing	NO COVERAGE

Hospice Care – Notes
1. Benefits are limited to members with a terminal condition, which requires the member's primary physician to certify, in writing, a life expectancy for the member of six (6) months or fewer. Hospice benefits begin on the date of admission to a hospice program.
2. 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.
3. 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.
4. Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
5. Benefits include family counseling related to the member's terminal condition.
6. Medical care services unrelated to the terminal condition under the hospice program are covered but are separate from the hospice benefit.

Hospice Care – Not Covered
1. Services you receive from an out-of-network provider.
2. Services for respite care, except as provided herein.
3. Room and board expenses in a residential hospice facility.
4. Services for dialysis treatment you receive from hospice or a hospital program for hospice care.
5. Custodial care.
6. Services for food or home-delivered meals you receive from hospice or a hospital program for hospice care.

Hospital Inpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• 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 provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic 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	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Hospital Inpatient Care – Notes
1. The health 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.
2. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: a. potential donor testing; b. donor evaluation and work-up; and c. hospital and professional services related to organ procurement.
3. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine; b. diagnostic pathology consisting of laboratory and pathology tests; c. 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 d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Hospital Inpatient Care – Notes
4. The health plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
5. For facility services related to bariatric surgery, please refer to "Bariatric Surgery."
6. The plan covers telehealth services.
7. The plan covers rapid whole genome sequencing for members who are 21 years of age or younger when they: a. have a complex or acute illness of unknown origin, and b. are receiving inpatient hospital services in an intensive care unit, a neonatal, or high acuity pediatric care unit. Coverage is subject to medical necessity criteria consistent with Minnesota Statutes Section 62A.3098.

Hospital Inpatient Care – Not Covered
1. Charges for inpatient admissions which are primarily for diagnostic studies.
2. Personal comfort items such as telephone, television.
3. Communication services provided on an outpatient basis or in the home.
4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Hospital Outpatient Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient hospital/facility services • 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 provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Laboratory services	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Facility freestanding ambulatory surgery center services	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Urgent care center visits including: ■ facility billed services	You pay 20% coinsurance after deductible	Same as in-network services
■ facility laboratory services	You pay 20% coinsurance after deductible	Same as in-network services
■ facility diagnostic imaging services	You pay 20% coinsurance after deductible	Same as in-network services

Hospital Outpatient Care – Notes
1. 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.
2. 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.
3. Coverage is provided for the 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.

Hospital Outpatient Care – Notes
4. 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.
5. The health plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
6. For facility services related to bariatric surgery, please refer to "Bariatric Surgery."
7. Assisted reproductive technology services are subject to an annual maximum limit of $10,000 per person for medical services and prescription drugs combined.
8. The plan covers telehealth services.

Infusion Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
• 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	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

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

Infusion Therapy – Not Covered
1. Home/suite infusion services or supplies not specifically listed as covered services.
2. 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:	In-network Providers	Out-of-network Providers
● Prenatal hospital/facility services	You pay nothing	Same as in-network services
● Prenatal professional services	You pay nothing	Same as in-network services
● Health care provider services for: ■ delivery in a hospital/facility ■ examination of the newborn infant while the birthing member/mother is inpatient	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
■ postpartum care ● office visit	You pay nothing	You pay 20% coinsurance after deductible
● all other eligible services - office/clinic	You pay nothing	You pay 20% coinsurance after deductible
● all other eligible services - outpatient hospital/facility	You pay nothing	You pay 20% coinsurance after deductible
● Hospital/facility services for: ■ delivery ■ postpartum care	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
● Acupuncture services that are medically necessary and appropriate	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Maternity Care – Notes
1. 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 birthing member/mother and newborn child.
2. Services related to miscarriage, ectopic pregnancy, cesarean section, and abortion (including related pre-abortion and follow-up services) are covered as delivery.
3. Prenatal care is the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, gestational diabetes screening, 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.
4. Postpartum care is the comprehensive postnatal visits to provide a full assessment of the birthing member/mother's and infant's physical, social, and psychological well-being. Covered services include but are not limited to care for mood and emotional well-being, infant care and feeding, sexuality, contraception, birth spacing, sleep and fatigue, physical recovery from birth, chronic disease management, and health maintenance.
5. The plan covers services provided to the newborn child from the moment of birth, if added to the health plan, including routine nursery care and care for the treatment of congenital defects, birth abnormalities, and prematurity diagnosed by a health care provider.
6. Under federal law, this health plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows: a. inpatient hospital coverage for the birthing member/mother if covered under this health 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 plan. Please refer to "Home Health Care." b. inpatient hospital coverage for the newborn, if added to the health 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

Maternity Care – Notes
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."
7. Under federal law, the health plan may require that a provider obtain authorization from the health plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
8. For laboratory and diagnostic imaging services billed by a health care provider, 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."
9. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.
10. You pay nothing for medical transfers (ambulance) from one medical facility to a different medical facility for a birthing member/mother, newborn, and newborn siblings when prescribed by a health care provider.

Maternity Care – Not Covered
1. Services for or related to childbirth deliveries in the home.
2. Adoption fees.
3. Services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted reproductive technology, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan.
4. Childbirth classes.
5. 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.
6. Services for donor ova or sperm.
7. Services for or related to an elective cesarean (C)-section for nonmedical indications.
8. Services for or related to the selection of gender in embryos.

Medical Equipment and Supplies

The Plan Covers:	In-network Providers	Out-of-network Providers
• Durable medical equipment (DME) • Amino acid-based elemental formula • Catheters (including intermittent) and related supplies • Continuous Glucose Monitors (CGMs) • Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) • Wigs (scalp hair prostheses) for hair loss due to a medical diagnosis • Hearing aids for hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) standard (non-deluxe) hearing aid for each ear every three (3) years	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Insulin infusion devices	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Blood Glucose Meters (BGMs)	You pay nothing	You pay 20% coinsurance after deductible
• Orthotics	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Prosthetics, such as breast prostheses, artificial limbs, and artificial eyes	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Cochlear implants	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
• Non-investigative bone conductive hearing devices	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Medical Equipment and Supplies – Notes
1. The health plan covers the approved rental, 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.
2. The health plan covers the approved rental or purchase, fitting, necessary adjustments, repairs, and replacements of durable medical equipment and supplies, including, but not limited to: a. Prosthetic devices (custom fitted to the member's needs) which replace all or part of an absent body part and its adjoining tissues or replace all or part of the function of a permanently inoperative or malfunctioning body part (excluding dental appliances and the replacement of cataract lenses). Initial subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered; b. a rigid or semi-rigid supportive orthotic device (custom fitted to the member's needs) which restricts or eliminates motion of a weak or diseased body part; c. supplies and accessories necessary for the effective functioning of covered durable medical equipment.

Medical Equipment and Supplies – Notes
3. The health plan covers the approved rental, purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use including supplies and accessories necessary for the effective functioning of covered durable medical equipment.
4. Rental costs cannot exceed the total cost of purchase.
5. Amino acid-based elemental formula, a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for 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. A member may be placed on an amino acid-based formula when 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 include Neocate®, EleCare®, Vivonex®, and Tolerex®.
6. The health plan covers the approved rental, purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part.
7. The plan covers wigs (scalp hair prostheses, including all equipment and accessories) when prescribed by a health care provider. Maximum of one (1) wig per person per calendar year. Coverage is limited to a maximum benefit of $1,000 per calendar year. When hair loss is due to alopecia areata, there is no dollar limit for a wig. Deductible does not apply.
8. Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
9. Standard (non-deluxe) hearing aids. Maximum of one (1) hearing aid for each ear every three (3) years per person.
10. You will pay no more than $50 per month for all eligible medical supplies to treat chronic diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors. Select medical supplies may be eligible for coverage under the Prescription Drugs benefit only.

Medical Equipment and Supplies – Not Covered
1. Services for or related to hearing aids or devices, except as provided herein.
2. Durable medical equipment, supplies, and prosthetics for convenience, personal, or recreational use.
3. 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.
4. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.
5. Blood pressure monitoring devices.
6. Replacement of properly functioning durable medical equipment.
7. Repair, maintenance or replacement of rental equipment (this is included in the price of the rental equipment).
8. Duplicate equipment, prosthetics, or supplies.
9. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
10. Devices for maintenance services.
11. Biofeedback devices in the home.
12. Wigs (scalp hair prostheses), except as provided herein.
13. Charges for breast pumps, except as provided herein.
14. Services for eyeglasses or contact lenses, or prescribing or fitting eyeglasses or contact lenses (except for the initial

Medical Equipment and Supplies – Not Covered
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:	In-network Providers	Out-of-network Providers
● Primary care office visits	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● Specialty care office visits	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● E-visits ● Telephone consultations	You pay nothing after e-visit or telephone consultation $20 copay	You pay 20% coinsurance after deductible
● Urgent care center visits including: ■ office visit for urgent care	You pay nothing after urgent care professional office visit $20 copay	Same as in-network services
■ professional laboratory services for urgent care	You pay nothing	Same as in-network services
■ professional diagnostic imaging services for urgent care	You pay nothing	Same as in-network services
■ all other professional services for urgent care	You pay nothing	Same as in-network services
● Retail health clinic ■ office visit	You pay nothing after retail health clinic office visit $20 copay	You pay 20% coinsurance after deductible
■ laboratory services	You pay nothing	You pay nothing
■ all other professional services	You pay nothing	You pay 20% coinsurance after deductible
● Professional office and outpatient laboratory services	You pay nothing	You pay nothing
● Professional office and outpatient diagnostic imaging services	You pay nothing	You pay nothing
● Professional services received at a freestanding ambulatory surgery center	You pay nothing	You pay 20% coinsurance after deductible
● Omada program for members age 18 or older for: ■ Omada for prevention ■ diabetes management ■ hypertension management	You pay nothing	NO COVERAGE
● Acupuncture services that are medically necessary and appropriate	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
● Assisted reproductive technology	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
● All other professional services – office/clinic	You pay nothing	You pay 20% coinsurance after deductible

The Plan Covers:	In-network Providers	Out-of-network Providers
• All other professional services – outpatient hospital/facility	You pay nothing	You pay 20% coinsurance after deductible

Office Visit and Professional Services – Notes
1. Diabetes Self-Management Education and Support (DSMES) Services: When your health care provider certifies that you require diabetes education and support either individually or in a group setting, coverage is provided for the following situations when rendered through DSMES services: a. when diabetes is diagnosed; b. when a new drug is prescribed; c. when diagnosed with eye disease, foot problems, or kidney disease related to diabetes; d. treatment for diabetic related complications such as uncontrolled blood sugar levels; e. emergency room visit or hospital stay to treat your diabetes.
2. The plan covers eligible services for the treatment of diagnosed Lyme disease.
3. A retail health clinic is located in a retail establishment and provides medical services for a limited list of eligible symptoms. The list of medical services and/or treatable symptoms is available at the retail health clinic.
4. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: a. potential donor testing; b. donor evaluation and workup; and c. hospital and professional services related to organ procurement.
5. For a member participating in an approved clinical trial, the plan only covers services that would be covered if not enrolled in an approved clinical trial.
6. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine b. diagnostic pathology consisting of laboratory and pathology tests c. 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 d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.
7. The plan covers eligible drugs, 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 is billed by the health care provider and eligible under the “Office Visit and Professional Services” benefit.
8. 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.
9. Please refer to “Preventive Care” for female sterilization.
10. Omada Health helps people stay healthy and avoid or control diabetes and heart disease. You will have access to online programs for losing weight and for lowering your blood sugar and blood pressure. For more information about Omada Health options, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card. The Omada Program is from Omada Health, Inc., an independent virtual healthcare provider.
11. The following services are covered at the in-network level if received from out-of-network providers:

Office Visit and Professional Services – Notes
a. voluntary planning of the conception and bearing of children; b. diagnosis of infertility; c. testing and treatment of a sexually transmitted disease; and/or d. testing of AIDS or other HIV-related conditions.
12. E-visit is a patient-initiated, limited, written online evaluation and management service provided by a health care provider to communicate with an established patient. E-visits are not real-time interactions with a health care provider. For more information about virtual care options, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.
13. The plan covers telehealth services.
14. Assisted reproductive technology services are subject to an annual maximum limit of $10,000 per person for medical services and prescription drugs combined.
15. The plan covers hearing aid examinations/fitting/adjustments.
16. Eligible acupuncture services are limited to 20 visits per person per calendar year for all providers combined.
17. Coverage is provided for the 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.

Office Visit and Professional Services – Not Covered
1. Separate charges for pre-operative and post-operative care for surgery.
2. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein.
3. 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.
4. 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.
5. Services for or related to reversal of sterilization.
6. Medication Therapy Management (MTM) services.

Physical, Occupational, and Speech Therapy

The Plan Covers:	In-network Providers	Out-of-network Providers
● Habilitative and rehabilitative office visits from a physical therapist	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● Habilitative and rehabilitative therapies from a physical therapist	You pay nothing after $20 copay	You pay 20% coinsurance after deductible
● Habilitative and rehabilitative office visits from an occupational therapist	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● Habilitative and rehabilitative therapies from an occupational therapist	You pay nothing after $20 copay	You pay 20% coinsurance after deductible
● Habilitative and rehabilitative office visits from a speech or language pathologist	You pay nothing after office visit $20 copay	You pay 20% coinsurance after deductible
● Habilitative and rehabilitative therapies from a speech or language pathologist	You pay nothing after $20 copay	You pay 20% coinsurance after deductible

Physical, Occupational, and Speech Therapy – Notes
1. 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.
2. For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
3. Office visits include an evaluation or re-evaluation of the following therapies: a. physical; b. occupational; c. speech; or d. swallowing.
4. For laboratory and diagnostic imaging services billed by a health care provider, 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."

Physical, Occupational, and Speech Therapy – Not Covered
1. 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.

Preventive Care

The Plan Covers:	In-network Providers	Out-of-network Providers
Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, 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), American Academy of Pediatrics (AAP), and the Internal Revenue Service (IRS). For more information regarding preventive care services, log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.		
● Adults and children age six (6) and older		
■ preventive physical examinations	You pay nothing	You pay nothing
■ routine vision screening	You pay nothing	You pay nothing
■ hearing screening	You pay nothing	You pay nothing
■ 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
■ diagnostic services and procedures ■ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	You pay nothing
■ routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	You pay nothing
■ mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	You pay nothing
■ colorectal cancer screening ■ prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	You pay nothing
● Infants and children ■ preventive physical examinations from birth to age six (6) ■ developmental assessments from birth to age six (6)	You pay nothing	Same as in-network services
■ pediatric immunizations from birth to age 18	You pay nothing	Same as in-network services

Preventive Care – Notes
1. Preventive care services are consistent with applicable state and federal statutes, regulations, and related guidance.
2. Preventive examinations include a complete medical history, complete physical examination, as well as screening and counseling for obesity, depression, and tobacco cessation.

Preventive Care – Notes
3. Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage log onto the member website at bluecrossmn.com or call customer service at the telephone number listed on the back of your member ID card.
4. 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.
5. Services for complications related to female contraceptive drugs, devices, and services for women with reproductive capacity 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.
6. The plan covers: an initial physical examination to confirm pregnancy, folic acid supplement for members planning to become pregnant, counseling for contraceptive methods, counseling and support for breastfeeding, the purchase of an electric or manual breast pump, or rental charges for a hospital-grade breast pump, and breast pump supplies. Personal electric breast pumps are limited to one (1) per pregnancy.
7. The plan covers screening for sexually transmitted disease or HIV at the in-network level.
8. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. when services are for: complications or an illness/injury diagnosed as a result of preventive care services, or preventive care services in excess of applicable state and federal preventive recommendations and criteria.
9. Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer: a. diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test; b. diagnostic imaging screening services such as barium enema; c. surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services; and d. 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.
10. The plan covers follow-up diagnostic services or testing that your health care provider determines you require following your preventive mammogram.

Reconstructive Surgery

The Plan Covers:	In-network Providers	Out-of-network Providers
● Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part ● Reconstructive surgery performed 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 including: ■ 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	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Reconstructive Surgery – Notes
1. Congenital means present at birth.
2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

Reconstructive Surgery – Not Covered
1. Dentures, regardless of the cause or condition, and any associated services including bone grafts.
2. Dental implants and associated services, except when related to services for cleft lip and palate.

Skilled Nursing Facility Care

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Skilled Nursing Facility Care – Notes
1. Skilled care ordered by a physician includes skilled care ordered by an advanced practice nurse or physician assistant when ordered within the scope of their licensure.
2. Coverage is limited to a maximum benefit of 120 days per person per calendar year.

Skilled Nursing Facility Care – Not Covered
1. Custodial care.
2. 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.
3. Services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience.
4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

Transplant

The Plan Covers:	In-network Providers	Out-of-network Providers
• Bone marrow/stem cell • Heart • Heart-lung • Liver • Liver-kidney • Lung	You pay 20% coinsurance of the transplant payment allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	NO COVERAGE

Transplant – Notes
1. Prior authorization must be obtained before a transplant procedure.
2. The donor's medical expenses directly related to the organ donation are covered under the recipient's plan. Treatment of any medical complications that occur to the donor are not covered under the recipient's plan.
3. Eligible transplants not performed in conjunction with a major organ transplant noted above are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," and "Office Visit and Professional Services." 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.
4. BDCT facilities have a contract with the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to provide transplant procedures. These facilities have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Facilities are reevaluated regularly to ensure that they continue to meet the established criteria to participate in this network.
5. Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) provider level of benefits when the transplant services are not available at a BDCT provider.
6. If you live more than 50 miles from a BDCT provider, there is a benefit available for travel expenses (consistent with IRS guidelines) directly related to a preauthorized transplant.

Transplant – Not Covered
1. Services for or related to nonhuman or mechanical devices that serve as a human organ. An exception is services for the use of an FDA-approved Total Artificial Heart (TAH) to serve as a temporary bridge to a heart transplant.
2. Benefits for travel expenses when you are using a Non-BDCT provider.
3. Transplant services you receive from an out-of-network provider.

General Exclusions

Except as specifically provided in this health 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. If you have any questions concerning any of the general exclusions, call customer service at the telephone number on the back of your ID card.

No benefits will be provided for the following:

1. Services which are not medically necessary and appropriate based on the definition of “medically necessary and appropriate” in “Terms You Should Know.”
2. Services which are experimental/investigative in nature.
3. Services that are prohibited by law or regulation.
4. Services rendered prior to your effective date of coverage.
5. Services incurred after the date of termination of your coverage, except as provided herein.
6. Services for dependents if you have employee-only coverage.
7. Services that are provided without charge, including services of the clergy.
8. Services rendered by a provider who is a member of your immediate family.
9. Services that are not within the scope of licensure or certification of a provider.
10. Services from providers who are not health care providers.
11. 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.
12. Autopsy.
13. Custodial care, nonskilled care, or adult daycare.
14. Personal care attendants, except as provided herein.
15. Services for or related to care that can be provided by a non-skilled caregiver who has been trained or is capable of being trained.
16. Room and board for outpatient services.
17. 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.
18. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
19. Services for or related to evaluations performed for administrative purposes including, but not limited to, obtaining/maintaining employment, disability determination, insurance, licensing, certification, or for participation in activities such as school, camp, or sports.
20. 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.
21. Services, testing, equipment, devices, technologies and supplies purchased or available over-the-counter, whether or not prescribed by a health care provider, unless covered under preventive care.
22. Services for or related to hearing aid devices and tinnitus maskers, except as provided herein.
23. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders that are not medically necessary and appropriate, such as services provided in a school setting.
24. 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.

25. 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 plan and you elect this coverage as primary.
26. Charges for the covered patient's failure to keep a scheduled visit.
27. Charges billed by your provider for the completion of a claim form.
28. Any other medical or dental service or treatment or prescription drug, except as provided herein.
29. 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.
30. Fees, dues, exercise therapy, or any non-prescription substance utilized for the sole purpose of weight management.
31. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
32. Services which are not prescribed by or performed by or upon the direction of a professional provider.
33. 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.
34. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
35. 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.
36. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
37. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that they will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
38. Services for or related to acupuncture, except as provided herein.
39. Services for or related to the prescribed use of recreational therapy or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages.
40. Services for or related to educational therapy and other nonmedical services normally provided in an educational setting including, but not limited to, special education classes, tutoring, boarding school, or school tuition.
41. Services for or related to nonmedical self-care or self-help training including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, or spas.
42. Services for furnishing medical records or reports and associated delivery services.
43. 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.
44. 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.
45. Services for or related to therapeutic massage.
46. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm, except as provided herein.
47. Charges for donor ova or sperm.
48. 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.

49. 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.
50. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription drugs; 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.
51. Services and fees for or related to health clubs and spas.
52. Services for or related to the repair of scars and blemishes on skin surfaces, except as provided herein.
53. Services for hippotherapy (equine movement therapy).
54. Maintenance services unless part of a specialized therapy for the member's condition.
55. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
56. Out-of-network provider-initiated communications.
57. Services for educational classes, educational programs, and services primarily educational in nature, except for services such as medical nutrition therapy and nutritional counseling, parent education following early maternity discharge, prenatal education, diabetes outpatient self-management training and education, specialty drug patient education that cannot be provided by a retail pharmacy, preventive patient education/counseling, or as otherwise required by law.
58. Services for or related to preparing a person with disabilities for employment, or assisting an individual to return to work.
59. Services for or related to gene therapy or cellular therapy until they have been evaluated by the claims administrator and deemed eligible for coverage.
60. 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, including, but not limited to, homeopathy, naturopathy, and reiki.
61. Services for or related to chelation therapy that are not medically necessary and appropriate.
62. Drugs that are not approved by the Food and Drug Administration (FDA).
63. Prescription drugs including, but not limited to, biological products, biosimilars, and gene or cellular therapies, that have an alternative drug available that is similar in safety and effectiveness and is more cost-effective.
64. Solid or liquid food, any standard or specialized formula (including infant formula, with intact proteins), banked breast milk, nutritional supplements, and electrolyte solution, except as provided in the "Benefit Chart."
65. Enteral feedings, except as provided in the "Benefit Chart."
66. Charges for administering drugs that can be self-administered.
67. Self-administered drugs that are available for coverage under any applicable pharmacy/prescription drug benefit.
68. Vitamins, dietary supplements, and over-the-counter (OTC) drugs, unless listed on the covered drug list and prescribed by a health care provider.
69. Charges for food supplements.
70. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
71. Intact protein/protein isolates including, but not limited to, semisynthetic, natural, plant-based, or hydrolyzed, when taken orally (for example, protein powders).
72. Bulk powders, chemicals, ingredients, and products used in prescription drug compounding.
73. Services for or related to fetal tissue transplantation.
74. Travel expenses for an organ donor.

75. Organ donor expenses for complications incurred after the organ is removed if the donor is not covered under this health plan.
76. Organ donor expenses when the recipient is not covered for the organ transplant under this health plan.
77. Outpatient prescription drugs whether purchased through a home delivery pharmacy/90dayRx or a retail pharmacy, are not covered under this plan. Refer to your employer for prescription drug plan materials that explain your coverage.
78. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).

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. The claims administrator's review includes applying evidence-based benefit coverage criteria that may require a provider to submit a treatment plan. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply after a prior authorization is approved or admission notification is completed.

Prior authorization and admission notification are only required for specific services. These requirements apply to the start of services and ongoing services you may receive.

If prior authorization is not completed and at the point the claim is processed it is found that services received were not medically necessary, you could be held liable for all the charges.

The claims administrator will not retrospectively deny or limit coverage for a health care service if prior authorization was not required, unless there is proof of fraud or misinformation.

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

An authorization for treatment of a chronic condition that is expected to last one year or more and requires ongoing medical attention to effectively manage the condition or prevent an adverse health event or limits one or more activities of daily living does not expire unless the standard of treatment for that health condition changes.

Prior authorization is not required when the care you receive is:

- for a medical emergency
- outpatient mental health treatment or outpatient substance use disorder treatment. Certain drugs may require prior authorization
- antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network. Certain drugs may require prior authorization
- Services with rating of A or B from United States Preventive Services Task Force (USPSTF), immunizations recommended by Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130
- pediatric hospice services
- treatment delivered through a neonatal abstinence program provided by a pediatric pain or palliative care subspecialists

Prior Authorization, Including Concurrent Review

The prior authorization process ensures that you receive medically necessary, high-quality care in the appropriate clinical setting (level of care), in accordance with evidence-based standards. The initial prior authorization should be obtained 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 and behavioral health policies. The claims administrator reserves the right to revise, update and/or add to this list at any time without notice.

If additional services that require prior authorization are needed beyond what was initially approved, a new authorization is required and should be completed before any additional services are received. For inpatient facility services, this is referred to as a concurrent review of a continued stay.

The most current list of services requiring prior authorization is available on the claims administrator's website at bluecrossmn.com or by contacting customer service at the telephone number listed on the back of your member ID card.

Participating Providers in Minnesota and Bordering Counties

When you receive services that require prior authorization from a participating provider in Minnesota and bordering counties, the provider is required to obtain prior authorization for you.

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

When you receive services that require prior authorization from a nonparticipating provider or any provider outside of Minnesota/bordering counties, you may have to obtain prior authorization yourself. 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.

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 requests that you or the provider contact them at least 10 business 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 business 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 provider 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

- **Planned admissions -** Your provider, or you, must inform the claims administrator that you will be admitted for inpatient hospitalization services prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency/unplanned admissions -** Your provider, or you, must inform the claims administrator of an unplanned or emergency admission to a hospital as soon as reasonably possible, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, the claims administrator may reach out to you or your provider to ensure your needs are met and to help you when you are discharged.

Acknowledgement of an admission notification is not the same as prior authorization. You, or your provider, may also be required to obtain prior authorization for the services or procedures performed during a hospital stay, such as an elective surgery or treatment 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 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.

You may be held financially responsible if notification is not completed when using nonparticipating facilities. To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating facility 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:	Services that Require Prior Authorization	Planned Admission Notification	Emergency/Unplanned 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 business 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 business 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 business 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 plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **in-network** or **out-of-network.**

In-network Care

In-network care is care you receive from providers in the health plan's network.

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

Out-of-network Care

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

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."

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

Out-of-area Care

Your health 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 BlueCard Traditional network will be covered at the higher level of benefits. If you receive covered non-emergency services from a provider who is not part of the local Blue Cross and Blue Shield BlueCard Traditional network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment immediately.

Emergency services will be covered at the higher benefit level. If the treatment results in an admission, please refer to "Health Care Management" for admission notification requirements.

Non-emergency benefits apply to follow-up or scheduled services once your condition has stabilized.

If the illness or injury is not an emergency, services will be paid at the lower, out-of-network level. See "Out-of-network Care" for more information about coverage.

General Provider Payment Methods

This is a general summary of provider payment methodologies only. 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.

Participating Providers

Under the payment arrangements of the participating provider agreements, providers have agreed to provide care and receive the contractual allowed amount as payment in full, less member cost-sharing (e.g., deductible, coinsurance, copays) or amounts paid by other insurance for health services. The allowed amount may vary from one (1) provider to another for the same service. These payment amounts generally result in the provider being paid less overall than its billed charges.

The allowed amount may not include other payment adjustments which may occur periodically including settlements to

capture complex claims accurately, settlements for withhold, capitation, outlier cases, fee schedule adjustments, rebates, prospective payments, or other methods. Such adjustments are completed without reprocessing individual claims. These settlements will not cause any change in the amount members paid at the time of claims processing. If the payment to the provider is decreased, the amount of the decrease is credited to the claims administrator, and if the payment to the provider is increased, the claims administrator will pay that cost.

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 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 plan. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Professional (i.e., doctor visits, office visits)
  - **Fee-for-Service or Discounted Fee-for-Service -** Providers are paid for each service or bundle of services. Payment is based on a fee schedule allowance for each service or a percentage of the provider's billed charges.
  - **Withhold and Bonus Payments -** Providers are paid based upon a fee schedule or percentage of billed charges, and a portion 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 care while demonstrating the optimal treatment for patients.
  - **Capitation Payments –** Providers may be paid in part based upon a per person per month capitation amount. This amount is calculated based upon historical costs and volumes to determine the average costs for providing medically necessary care to a patient.

- Institutional (i.e., hospital and other facility provider)
  - Inpatient care
    - **Payments for each Case (case rate) or for each day (per diem) -** Providers are paid a fixed amount based upon the member's diagnosis at the time of admission in a hospital facility.
    - **Percentage of Billed Charges -** Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient services.
    - **DRG Payments –** All Patient Refined Diagnosis Related Groups (APR DRG) or other DRG payments apply to most inpatient claims. DRG payments are based upon the full range of services the patient typically receives to treat the condition.
  - Outpatient care
    - **Enhanced Ambulatory Patient Groupings (EAPG) –** Used for payment on most outpatient claims. EAPG payments are based upon the full range of services the patient typically receives to treat the condition.
    - **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 during one (1) visit.
    - **Percentage of Billed Charges –** Providers are paid a percentage of their regular billed charges for services.

- Special Incentive Payments
  As an incentive to promote high quality, cost-effective care and to recognize those providers that participate in certain quality improvement projects, providers may be paid extra amounts based on the quality of the care and on savings that the provider may generate through cost effective care. Certain providers also may be paid in advance in recognition of their efficiency in managing the total cost of providing high quality care and implementing programs such as care coordination. Quality is measured against adherence to recognized quality criteria and improvement such as optimal diabetes care, supporting tobacco cessation, cancer screenings, and other services. Cost of care is based on quantifiable criteria to demonstrate managing claims costs. These quality and cost incentives are not reflected in claims payment.

- Pharmacy Payment
  Generally, four (4) types of pricing are compared and the lowest amount is paid the:
  - average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
  - pharmacy's retail price;
  - maximum allowable cost the claims administrator determines by comparing market prices (for generic drugs only); or
  - pharmacy's billed charge.

Nonparticipating Providers

A nonparticipating provider does not have any agreement with the claims administrator or another Blue Cross and/or Blue Shield plan. Nonparticipating providers are not credentialed or subject to the requirements of a participating agreement.

The allowed amount for a nonparticipating provider is not the amount billed and is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the billed charge. Members are responsible to pay the difference between the claims administrator's allowed amount and the nonparticipating provider's billed charge, except as described in "Special Circumstances." This amount can be significant and does not count toward any out-of-pocket limit contained in the plan.

Payment for covered services provided by a nonparticipating provider will be made at the out-of-network level. Please refer to "Out-of-network Care" and "In-network Care" for additional detail on covered services received in-network and out-of-network.

Example

The following 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 plan covers 80% for participating providers and 60% for nonparticipating providers.

	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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

What is "balance billing" (sometimes called "surprise billing")?

Nonparticipating providers and facilities that have not signed a contract with your health plan may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by a nonparticipating provider.

Your Rights and Protections Against Surprise Medical Bills

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. These circumstances could include nonparticipating providers in an in-network hospital, your in-network physician using a nonparticipating laboratory, post-stabilization following emergency services, or medically necessary air ambulance services.

When you get emergency care or get treated by a nonparticipating provider at an in-network hospital or ambulatory surgery center, you are protected from surprise billing or balance billing. In-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum.

When a claim is identified as a special circumstance, payment will be made to the nonparticipating provider when required by law. These nonparticipating providers can negotiate with the claims administrator for a higher allowed amount after the initial payment has been made. This may result in an increase to the amount applied to your in-network cost-sharing. For additional information, you can contact customer service at the telephone number listed on the back of your member ID card or log onto your claims administrator's website at bluecrossmn.com.

You are protected from balance billing for:

- Certain services at an in-network hospital or ambulatory surgery center - When you get services from an in-network hospital or ambulatory surgery center, certain providers may be nonparticipating providers. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.
- Emergency services - If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Surprise Air Ambulance Bills – Emergency air ambulance transportation that is provided to you by nonparticipating providers will be reimbursed at in-network cost-sharing rates. Nonparticipating air ambulance providers cannot balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum. Please refer to "Ambulance" for coverage of benefits.

Steps You Can Take

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 services, this could be a "surprise" or "balance" bill. If you have questions regarding what a "surprise" or "balance" bill is, call customer service at the number on the back of your ID card or visit the claims administrator's website at bluecrossmn.com. 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. You may appeal a decision that your claim does not qualify as a special circumstance. Please refer to "Appeal Process."

Billing Errors

When the claims administrator determines or receives notice from a patient or other person that a bill from your health care provider to a patient for health treatment or services may contain one or more billing errors, the claims administrator will:

1. notify you of the potential billing error within 30 days,
2. review the bill and request that the health care provider correct any billing errors found, and
3. within 30 days of completing the review, notify you when the review is complete and share the findings with you.

While the review is being conducted, the health care provider must not bill the patient for any health treatment or service subject to review for potential billing errors. If it is determined the patient overpaid the health care provider under the bill, the health care provider must, within 30 days after the completed review, refund to the patient the amount the patient overpaid.

A billing error is an error in a bill from a health care provider to a patient for health treatment or services that affects the amount owed by the patient according to that bill. Billing error includes but is not limited to:

1. miscoding a health treatment or service,
2. an error in determining whether a health treatment or service is covered under the patient's health plan, or
3. an error in determining the cost-sharing owed by the patient.

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. prostheses 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.

Unrestricted Access for Rare Disease

If you or your dependent believe you have a rare disease, call customer service at the telephone number on the back of

your ID card. They will connect you with the care management team.

You are covered at the higher in-network level of benefits for care received in or outside the provider network for licensed health care provider services related to the diagnosis, monitoring, and treatment of a rare disease. You may be responsible for additional expenses when services are received outside of Minnesota. This benefit does not apply to drugs received from a retail pharmacy.

If you are later definitively diagnosed with a disease or condition that is not a rare disease, you must notify the claims administrator. The claims administrator will assist you in making the transition from an out-of-network to an in-network provider. When it is determined you do not have a rare disease, coverage will continue at in-network benefits for 60 days. After this 60-day period, services from an out-of-network provider will be covered at out-of-network benefits.

A rare disease is a disease or condition that:

1. is chronic, serious, life-altering or life-threatening affecting fewer than 200,000 people in the United States;
2. affects more than 200,000 people in the United States for which there is a drug that has been designated as a drug for a rare disease or condition pursuant to federal law; and
3. is included on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health or for member or dependent with inconclusive or conflicting lab or clinical test results, had had at least two clinical consultations for the specific complaint, and documentation in their medical record of a developmental delay, developmental regression, failure to thrive, or progressive multisystemic involvement.

Biomarker Testing

The claims administrator covers biomarker testing to diagnose, treat, manage, and monitor illness or disease when the test provides clinical utility. A test's clinical utility may be demonstrated by medical and scientific evidence as explained in Minnesota Statutes Section 62Q.473.

A biomarker is a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression. Biomarker testing is the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing. Clinical utility is a test providing information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

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 (1) sex, to a transgender individual because of 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 applicable medical and behavioral health policies and/or federal law.

Inter-Plan Arrangements

Out-of-area Services

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 (1) of these inter-plan arrangements. The inter-plan arrangements are described below.

Plan Arrangements

When you receive care outside of the claims administrator's service area, you will receive it from one (1) 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 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

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 approval 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 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 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.

Medical evacuation due to a member illness will only be eligible for transport to the closest eligible facility. Transportation back to the United States would not be eligible unless the closest hospital with appropriate facilities was located in the United States.

Your Provider Network

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the health plan service area.

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 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 health care provider and facility provider is in-network. Your provider directory lists in-network providers in the claims administrator's 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 an in-network provider for your particular plan. Not every provider is an in-network provider for every plan. For a list of providers in the directory, visit bluecrossmn.com 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 bluecrossmn.com, or contact customer service at the telephone number listed on the back of your member ID card.

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 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.

Continuation for members who are undergoing treatment within the first trimester of pregnancy is up to 120 days of coverage.

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 plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) 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 a participating provider as required under the terms of your coverage under the health 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.

Continuation for members who are undergoing treatment within the first trimester of pregnancy is up to 120 days of coverage.

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 plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) 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 – Transition of Prior Authorization

If you have an active prior authorization from your prior health plan, the claims administrator will comply with the approved prior authorization for health care services for at least the first 60 days of your coverage with this plan. You or your attending health care provider may request transition of a prior authorization by sending the claims administrator documentation of the previous prior authorization. During the 60-day time period, the claims administrator will complete a new review of your services following its established prior authorization process. Please refer to "Medical and Behavioral Health Care Management" for more details on the prior authorization process.

General Information

Plan Administration

Plan Administrator

The general administration of the health plan and the duty to carry out its provisions is vested in the employer. The board of directors will perform such duties on behalf of the employer, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the employer, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the plan administrator generally has final authority to administer the health 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 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 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 plan;
3. prepare and distribute information to you explaining the health plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the health plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the health 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 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 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 plan and/or to provide advice and assistance in the general administration of the health plan. Such service agent(s) may also be given the authority to make payments of benefits under the health 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 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 plan or waive any of its terms.

The employer reserves the power at any time and from time to time (and retroactively) to terminate, modify or amend, in whole or in part, any or all provisions of the health plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which they have become entitled under the health plan. Any amendment to this health plan may be affected 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 plan will be determined by the employer each year. The claims administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The claims administrator's payment of claims is contingent upon the plan administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, any questions, claims, disputes, or litigation concerning or arising from the health 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 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 relating to in-network provider, out-of-network participating provider, or nonparticipating provider services. Claim reprocessing may result in changes to the amount paid at the time your claim was originally processed.

Medicare End Stage Renal Disease Program Registration

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.

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, except as described in “Special Circumstances.” 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 and Behavioral Health Policy Committee and Policies

The claims administrator uses externally-developed criteria, as well as internally-developed medical policies to apply benefits consistently for members. Internally developed policies are subject to approval by the claims administrator’s Medical and Behavioral Health Policy Committee, which consists of independent community physicians who represent a variety of 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 policies may be created or existing policies may change. Covered benefits will be determined in accordance with the policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical and behavioral health policies can be found at the member website. All medical and behavioral health 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 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 "Who is Eligible" while covered under this health plan if all of the following apply:

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

Adding New Employees

Coverage for you or your eligible dependents who were eligible on the effective date of the health 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 first day employed.

Adding New Dependents

Adding a Spouse and/or Stepchildren

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

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

Your newborn child or newborn grandchild is covered starting on the date of birth. If you submit an application more than 30 days after birth, your newborn child or newborn grandchild will be added retroactive to the date of birth and you will be responsible for any premium due from the date of birth.

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

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

Adding Disabled Dependents

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

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

Special Enrollment Periods

Special enrollment periods are periods when an eligible 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 plan administrator within 30 days** of the triggering event, unless otherwise noted below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 30 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission): ● loss of eligibility for employer-sponsored coverage ● plan no longer offers benefits ● termination of all employer contributions ● termination of employment or reduction in hours ● legal separation or divorce ● loss of dependent child status ● death of employee ● move outside HMO or ACO service area ● exceeding the plan's lifetime maximum ● employer bankruptcy ● COBRA exhaustion ● employee becomes entitled to Medicare
Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.
Gaining or becoming a dependent due to marriage.
Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.
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.
Child support order or other court order to provide coverage.

Changes in Membership Status

For the health 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 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 plan terminates.
2. For you and your dependents, the last day of the 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 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 the month the employee and spouse divorce or legally separate.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month:
   a. a covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
   b. the dependent child reaches the dependent-child age limit.
   c. 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 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

Generally, continuation coverage is the same coverage that you or your covered dependents had on the day before the qualifying event. You have the same rights under this plan as active employees or their dependents.

Qualifying Events

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

NOTE: You may have a right to special enrollment in a new plan, such as another employer plan.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct	Employee and dependents	● 18 months from the first of the month following the event, or ● Enrollment date in other group coverage.
Reduction in hours	Due to lay-off, leave of absence, strike, lockout, change from full-time to part-time employment	Employee and dependents	● 18 months from the first of the month following the event, or ● Enrollment date in other group coverage.
Total disability of employee	● You are not able to engage in or perform the duties of your regular occupation or employment within the first two (2) years of disability. ● After the first two (2) years, you are not able to perform any occupation for which you are educated or trained.	Employee and dependents	● Date total disability ends, or ● Date coverage would otherwise end.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Death of employee		Dependents	● Enrollment date in other group coverage, or ● Date coverage would otherwise end if the employee had lived.
Employee becomes enrolled in Medicare		Dependents	● 36 months from the date of the event, or ● Enrollment date in other group coverage, or ● Date coverage would otherwise end.
Divorce	● Spouse/ex-spouse who was covered on the day before the entry of the valid decree of dissolution of marriage.	Spouse/ex-spouse and any dependent children who lose coverage	● Effective date of other group coverage, or ● Date coverage would otherwise end.
Legal Separation	Under federal COBRA law, ● Spouse/ex-spouse who was covered on the day before the entry of the valid decree of dissolution of marriage. ● If coverage for spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event.	Spouse/ex-spouse and any dependent children who lose coverage	● Effective date of other group coverage, or ● Date coverage would otherwise end.
Dependent child is no longer eligible		Dependent child	● 36 months from the date of the event, or ● Enrollment date in other group coverage, or ● Date coverage would otherwise end.
Employer filing Chapter 11 bankruptcy	● You are a retiree of the employer filing Chapter 11 bankruptcy. ● Includes substantial reduction in hours 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.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
		Surviving spouse	● Lifetime continuation until the retiree dies, then an additional 36 months following the retiree's death. ● Lifetime continuation when retiree is deceased at time of event and spouse is already covered by the plan.

Qualifying Event Extensions

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

Total Disability of Employee

Under Minnesota law, when the employee becomes totally disabled while employed, the employee and dependents can remain in the group health plan indefinitely.

Employee Enrolled in Medicare

- Employee enrolled in Medicare, and
- Later experiences termination of employment or reduction in hours worked, and
- This occurs within 18 months after the date of the employee's Medicare enrollment.

Dependents may extend coverage for a maximum period of 36 months from the date of the event or the enrollment date in other group coverage or the date coverage would otherwise end.

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.

Total Disability of Dependent(s)

- You have continuation coverage because the employee was terminated from employment or had a reduction of hours, and
- The disability occurs prior to the end of the initial 18-month continuation period, and
- The Social Security Administration (SSA) determines a dependent covered under the initial continuation coverage is disabled at any time during the first 60 days of continuation.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 29 months from the date the employee leaves employment or until the date total disability ends or the date coverage would otherwise end, whichever comes first.

Second Qualifying Event

- You have continuation coverage because the employee was terminated from employment or had a reduction of hours, and
- The second qualifying event occurs prior to the end of the 18-month continuation period or 29-month disability extension, and
- The second qualifying event has at least a 36-month continuation period.

Dependents covered under the initial continuation coverage may extend coverage for a maximum period of 36 months from the date of the initial event or the enrollment date in other group coverage or the date coverage would otherwise end, whichever comes first.

Certain qualifying events allow lifetime continuation, refer to the Qualifying Event table above.

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 when 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, the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

The employee and dependents may extend coverage for a maximum of 24 months.

Continuation Notice Obligations

You or your dependents each are 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.

If your or your dependent's address changes, you must notify the employer in writing so the employer may mail you or your dependent important continuation notices and other information.

Contact the employer to determine how to elect continuation coverage.

Election of Continuation due to:	Action for Employee/Dependent	Action for Employer	Action for Eligible Employee/Dependent
• Termination of employment • Reduction in hours • Death of the employee • Employee becomes enrolled in Medicare	Notice must be provided to employer within 60 days of the event if the employer is not aware of the event.	Send the qualifying event notice to eligible individuals within 14 days of the event or upon receipt of notice to advise: • of the right to elect continuation coverage or • when continuation is not available and why.	Elect continuation coverage within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.
• Divorce or legal separation • Dependent child is no longer eligible	• Notice must be provided to employer within 60 days of the event. • Notice must be provided to employer within 60 days after a later divorce or legal separation when coverage was earlier terminated in anticipation of the divorce or legal separation.	Upon receipt of notice, notify the eligible individuals: • of the right to elect continuation coverage or • when continuation is not available and why.	Elect continuation within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.
Extension of continuation for: • Disability determination or • New qualifying event	Notice must be provided: • to employer within 60 days of the disability determination or new event and	Upon receipt of notice: • notify the eligible individuals of the right to elect continuation coverage, or	Elect continuation within 60 days of: • the qualifying event or • the date of the qualifying event notice, whichever is later.

Election of Continuation due to:	Action for Employee/Dependent	Action for Employer	Action for Eligible Employee/Dependent
	● before the end of the initial 18-month or 29-month continuation period.	● notify you when an extension is not available and why.	

Termination of Continuation Coverage Before the End of Maximum Coverage Period

Continuation coverage of the group member and dependents will automatically terminate when any one (1) of the following events occur:

- The employer no longer provides group health coverage to any of its employees.
- The premium for continuation coverage is not paid when due.
- If during an 18-month or 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the employer within 30 days of the final determination.
- Occurrence of an event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered employee 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 employer. 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.

Continuation Premiums

Premiums for continuation can be up to the group rate plus a two (2) percent administration fee.

Under federal law, 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.

If the qualifying event for continuation is the employee’s total disability, the administration fee is not permitted.

All premiums are paid directly to the employer.

Coordination of Benefits

Most health plans, including this plan, contain a coordination of benefits (COB) provision. The COB provision is used when you, your spouse, or your covered dependents received a health care service and had active benefits under more than one (1) plan at the time of that service.

When you have health care coverage under more than one (1) plan, benefits will be coordinated. The “Order of Benefits Rules” determines which plan provides benefits first. Your benefits under this plan are not reduced if the rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

Coordination of benefits is to ensure that your covered expenses will be processed, while ensuring that the claim charges are not overpaid. If you receive funds to pay a provider directly, and you receive more funds than you should have, you will be expected to repay any overpayment.

Definitions

These definitions apply only to this section.

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

   a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;
   b. coverage under a government plan or one required or provided by law; or
   c. individual coverage.

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

law, are excess to any private or other nongovernmental program.

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

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

2. "This plan" means the part of the plan document that provides health care benefits.
3. "Primary plan/secondary plan" means the Order of Benefits Rules establishing whether this plan is the primary plan or secondary plan when compared to the other plan covering the person.

   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.
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.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.
5. "Claim determination period" means a calendar year. However, it does not include any part of a year the person is not covered under this plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

This plan uses the following rules to establish which plan is the primary plan:

You and Your Dependents

1. When your other plan does not include order of benefit rules, then that plan is the primary plan.
2. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is the primary plan over the plan that covers the member as a dependent.

Dependent Children

1. Birthday Rule
   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
   b. If both parents have the same birthday, the plan that covered the parent longer is the primary plan.
2. Separated or Divorced Parents
   a. The plan of the parent with custody of the child is the primary plan.
   b. The plan of the spouse of the parent with custody is the secondary plan.
   c. When a court decree specifies the parent who is financially responsible for the child’s health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of that parent is the primary plan. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

Other

The plan of an individual who is covered as an employee is the primary plan over the plan of an individual who is either laid-off or retired.

When the member who received care is covered under the No-Fault Automobile Insurance Act or similar law or traditional automobile “fault” type coverage, that coverage applies benefits first.

When none of these circumstances applies, the plan that has continuously covered the individual for the longest time is the primary plan.

Medicare and TRICARE

This plan will comply with the Medicare Secondary Payor (MSP) and TRICARE provisions of federal law to determine

which plan is a primary plan and which is a secondary plan.

Medicare or TRICARE will be primary and this plan will be secondary only to the extent permitted by MSP or TRICARE rules.

When Medicare or TRICARE is the primary plan, this plan will coordinate benefits up to Medicare's or TRICARE's allowed amount.

Effect on Benefits of This Health Plan

When this section applies:

1. When the Order of Benefits Rules require this health plan to be a secondary plan, this part applies. Benefits of this health 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 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 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 plan are reduced each benefit is reduced in proportion to any applicable benefit limit, such as the deductible, of this health 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 and Right of Recovery

When another plan pays an amount that should have been paid under this plan, 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. 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; or
3. other organizations.

Any payment made or amount paid includes the reasonable cash value of any benefits provided in the form of services.

Reimbursement and Subrogation

Subrogation is the right to pursue another party for medical costs that were originally paid by this plan when another party was liable. This encompasses, but is not limited to, motor vehicle accidents, workers' compensation, and other injuries.

If the health plan pays benefits for covered services you incur as a result of any act of any person, and you later obtain full compensation, you or your dependents, heirs, guardians, executors, trustees, or other representatives are obligated to reimburse the health plan for the benefits paid. If you or your Dependents receive benefits under this health plan arising out of illness or injury for which a responsible party is or may be liable, the health plan is also entitled to subrogate against any person, corporation and/or other legal entity, or any insurance coverage, including both first- and third-party automobile coverages to the full extent the health plan provided any benefits.

The health plan's right to reimbursement and subrogation is subject to you obtaining full recovery from another source, as explained in Minnesota statutes sections 62A.095 and 62A.096. Unless the health plan is separately represented by its own attorney, the health plan's right to reimbursement and subrogation is subject to reduction for first, the health plan's pro rata share of costs, disbursements, and then reduced by reasonable attorney fees incurred in obtaining the recovery. For purposes of this section, full recovery does not include payments made by a health plan to, or for the benefit of, a covered person.

If the health plan is separately represented by an attorney, the health plan and the covered member, by their attorneys, may enter into an agreement regarding allocation of the covered member's costs, disbursements, and reasonable

attorney fees and other expenses. If the health plan and the covered member cannot reach agreement on allocation, the health plan and the covered member shall submit the matter to binding arbitration.

Notice Requirement

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

The plan administrator may delegate such functions to the claims administrator.

Duty to Cooperate

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

What May Happen to Your Future Benefits

If you or your dependent(s) pursue a settlement, judgement, or other recovery from any person or entity, including your own automobile or liability carrier, without first notifying the plan, the plan may determine that you, your dependents, heirs, guardians, trustees or other authorized representatives have failed to cooperate with the subrogation and reimbursement provisions which may impact resolution of your claims. The plan may recover any plan overpayment by reallocating the overpayment amount to pay, in whole or in part, for your future claims until the matter has been resolved.

Workers’ Compensation

This section applies if you receive treatment for an employment related illness/injury for which you are eligible to make a workers’ compensation claim. Claims for medical expenses from an employment related illness/injury should be first submitted to the workers’ compensation carrier for coverage unless the workers’ compensation carrier has disputed the claim. This plan will still cover eligible services that are provided to you that are not paid by workers’ compensation coverage for the treatment of an employment related illness/injury.

How to File a Claim

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

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

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 seeking repayment of claims already paid. The claims administrator may also seek rescission of the contract in instances of fraud and intentional misrepresentation or omission of material fact.

Right of Examination

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

No Third Party Beneficiaries

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

Release of Records

Claimants agree to allow all health care providers to give the claims administrator needed information about the care that they provide to them. If needed, a separate patient consent for the use and disclosure of substance use disorder counseling notes will be provided that includes a clear explanation of the scope of the consent. This includes information about care received prior to the claimants enrollment with the claims administrator where necessary. Your disclosure authorization is valid as long as you are continually insured or until revoked. The claims administrator may need this information to process claims, conduct utilization review, care management and quality improvement activities, conduct reimbursement and subrogation review, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Your Explanation of Benefits Statement

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

- the provider's actual charge;
- the allowable amount as determined by the claims administrator;
- the copays; deductible and coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the in-network provider will submit the bill as a claim for payment under its contract with the claims administrator, you will receive an EOB only when you are required to pay amounts other than your required copay.

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

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding in-network providers, coverage, operations or management policies, please contact customer service at the telephone number listed on the back of your member ID card or by mail at the address listed below. Please include your

identification and group numbers as displayed on your ID card.

Blue Cross and Blue Shield of Minnesota
Processing Center
P.O. Box 982800
El Paso, TX 79998

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

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

Fraud or Provider Abuse

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

Additional Information on How to File a Claim

Member Inquiries

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

Filing Benefit Claims

Authorized Representatives

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

Requests for Prior Authorization and Other Pre-Service Claims

For a description of how to file a request for prior authorization or other pre-service claim, please refer to "Health Care Management."

Requests for Reimbursement and Other Post-Service Claims

When a hospital, physician or other provider submits its own reimbursement claim, the amount paid to that provider will be determined in accordance with the provider’s agreement with the claims administrator or the local licensee of the Blue Cross Blue Shield Association serving your area. The claims administrator will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copay, coinsurance or deductible will also be identified in that EOB or notice. If you believe that the copay, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your health plan, you may file a claim with the claims administrator. For instructions on how to file such claims, you should contact customer service at the telephone number listed on the back of your member ID card.

Determinations on Benefit Claims

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

For a description of the time frames in which requests for prior authorization or other pre-service claims will be determined by the claims administrator and the notice you will receive concerning its decision, whether adverse or not, please refer to "Health Care Management."

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

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

to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

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

Appeal Process

Introduction

As described below, the claims administrator has two different processes to resolve appeals: one (1) for appeals that do not require a medical determination; and one (1) for appeals that do require a medical determination. With an exception described below, you are required to submit a first level appeal before you can exercise any other rights to appeal or other review. If the decision on that first level review is wholly or partially adverse to you, you may either file a second level appeal within the claims administrator or you may seek review external to the claims administrator. If you choose to file a second level appeal within the claims administrator, and that decision is wholly or partially adverse to you, you can then seek external review. There is an exception for cases that qualify for an expedited appeal. For those cases, you may seek external review at the same time you request an expedited first level appeal.

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

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

Definitions

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

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

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

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

First Level Appeals That Do Not Require a Medical Determination

First Level Oral Complaint

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

First Level Written Appeals

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

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

First Level Appeals that Require a Medical Determination

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

Utilization review applies only when the service requested is otherwise covered under this health plan.

In order to conduct utilization review, the claims administrator will need specific information. If you or your attending health care provider do not release necessary information, approval of the requested service, procedure, or admission to a facility provider may be denied.

Definitions

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

Concurrent review means utilization review conducted during a member's hospital/facility stay or course of treatment.

Determination not to certify means that the service you or your provider has requested has been found to not be medically necessary and appropriate or efficacious under the terms of this health plan.

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

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

Utilization review means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures and facilities, by a person or entity other than the attending health care provider, for the purpose of determining the medical necessity of the services or admission.

Standard First Level Appeal

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

Expedited First Level Appeal

When the claims administrator’s initial determination to not certify a health care service is made prior to or during an ongoing service requiring review and the attending health care provider believes that an expedited appeal is warranted, you and your attending health care provider may request an expedited appeal. You and your attending health care provider may appeal the determination over the telephone. The claims administrator’s appeal staff will include the consulting physician or health care provider if reasonably available. When an expedited appeal is completed, the claims administrator will notify you and your attending health care provider of the decision as expeditiously as the member's medical condition requires, but no later than 72 hours from the claims administrator’s receipt of the expedited appeal request. If the claims administrator declines to reverse their initial determination not to certify, you will be notified of your right to submit the appeal to the external review process described below.

Second Level Appeals to Blue Cross Internal Appeals Committee

If the claims administrator’s final decision on your first level appeal is wholly or partially adverse to you, you may appeal their final decision through external review, as described below. Alternatively, you may voluntarily appeal to the claims administrator’s internal appeals committee (second level appeal), as described in this section, before seeking external review. If you appeal to the claims administrator’s internal appeals committee, you may either have the appeal decided solely on the written submissions or you may request a hearing in addition to your written submissions. You will receive continued coverage pending the outcome of this process. You may request a form on which you can include all the

information necessary for your appeal. During the course of the claims administrator's review, the claims administrator will provide you with any new evidence that the claims administrator considers or relies upon, as well as any new rationale for a decision. If the claims administrator's decision is wholly or partially adverse to you, the notice will advise you of how to submit the decision to external review as described below. If you request, the claims administrator will provide you a complete summary of the appeal decision.

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

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

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

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

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

External Review

You must exhaust your first level appeals option prior to requesting external review unless: 1) the claims administrator waives the exhaustion requirement in writing; 2) the claims administrator substantially fails to comply with required procedures; or 3) you qualified for and applied for an expedited first level appeal of a medical determination and applied for an expedited external review at the same time.

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

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

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

Expedited External Review

Expedited external review will be provided if you request it after receiving an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have simultaneously requested an expedited internal appeal. Expedited external review will also be provided after receiving an adverse benefit determination that concerns (i) an admission, availability of care, continued stay, or health care services for which you received

emergency services but have not yet been discharged from a facility provider; or (ii) a medical condition of which the standard external review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

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

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

Privacy of Protected Health Information

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a Health 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.

Terms You Should Know

Accountable Care Organization (ACO) - A group of physicians, other health care providers, 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.

Adverse Benefit Determination - A decision relating to a health care service or claim that is partially or wholly adverse to the complainant. This includes:

- a decision relating to the coverage of nonparticipating provider services as described in “Special Circumstances.”
- a determination for health care services that is less intensive than the service specified in the original prior authorization request.

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 (1) provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." The allowed amount may include the provider’s applicable taxes, for example, the MinnesotaCare tax.

The allowed amount for participating providers

For participating 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, which may include an agreed upon fee schedule rate, case rate, withhold and/or capitation agreements, 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 in “Special Circumstances,” the allowed amount will be based upon one (1) 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) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (4) as may be required by federal law. 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 in “Special Circumstances,” the allowed amount will be based upon one (1) 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; (4) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (5) as may be required by federal law. 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.

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) - A procedure in which semen is placed in a vagina, cervix, or uterus.

Assisted Reproductive Technology (ART) - Treatments or procedures that are done to start a pregnancy. This may include handling eggs and sperm or embryos.

Attending Health Care Provider - A health care provider 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 (DSM), 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 cellular 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.

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.

Cellular Therapy - The transfer of cells into a person with the goal of improving a disease. Gene modified cell therapy removes the cells from a person’s body and alters the genetic material of the cell. The modified cells are then reintroduced into the body.

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 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 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 billed charge. Because payment amounts are negotiated to achieve overall lower costs, the allowed amount for participating providers is generally 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 the claims administrator 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 the claims administrator has 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 the claims administrator 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 the allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges $100 for a service, but the 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.

Continued Stay - A continuation of inpatient care services for a member with an existing prior authorization. A continued stay review determines if continued inpatient care is medically necessary and/or if the current health care facility is still the most appropriate to provide the level of care required for the patient. Also known as concurrent review.

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 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 calendar year before the health 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.

Dental Implant - Metal, screwlike posts surgically inserted in the jawbone to replace damaged or missing teeth with artificial teeth that look and function like real ones.

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 plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Diabetes Self-Management Education (DSME) - The process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. Diabetes self-management support (DSMS) refers to the support that is required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis. The overall objectives are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. Support can be behavioral, educational, psychosocial, or clinical. DSMES will be provided by one (1) or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one (1) of the instructors will be a registered nurse, dietitian, or pharmacist. DSMES must be consistent with the National Standards for Diabetes Self-Management Education.

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 patient-initiated, limited, written online evaluation and management service provided by a health care provider to communicate with an established patient. E-visits are not real-time interactions with a health care provider.

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 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.

Extended Hours Skilled Nursing Care (Private Duty Nursing) - Extended hours home care are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home.

Extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Facility - 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/suite infusion therapy provider, freestanding ambulatory surgery center, a home health agency, or freestanding birthing center when services are billed on a facility claim.

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

Freestanding Ambulatory Surgery Center - A freestanding facility that is not part of a hospital and performs medical and surgical services on an outpatient basis.

Gene Therapy - The introduction, removal, or change in the content of a person’s genetic material with the goal of treating or curing a disease. It includes therapies such as gene transfer, gene modified cell therapy, and gene editing.

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 provider, 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 provider. Health care providers include physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, pharmacists, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dieticians, licensed acupuncture practitioners, and supervised employees.

Home Health Agency - A preapproved facility that sends health care providers 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 diagnosed with 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 (MD), or osteopathy (DO). A hospital provides 24 hour-a-day professional registered nursing (RN) services.

Host Blue - A Blue Cross and/or Blue Shield licensee outside of Minnesota that has contractual relationships with providers in its designated service area that deliver the benefit of its arrangements with its local and ancillary providers eligible for Inter-Plan Programs, on behalf of Control/Home Licensee Members who incur claims within its service area.

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 partners for a period of at least 12 months. The inability to conceive may be due to either partner.

In-network Provider - A provider that has entered into a specific network contract with the claims administrator for this plan, or with the local Blue Plan.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (RN) 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.

Intermittent Skilled Nursing Care - Services consisting 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 agency.

Lifetime Maximum - The cumulative maximum payable for specified covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health 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.

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.

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

Marriage/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 that a provider, exercising prudent clinical judgment and nondiscriminatory determinations, 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 drug is medically necessary and appropriate. No benefits will be provided unless the claims administrator determines that the service, supply or covered drug 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)*.

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

Opioid Treatment - Treatment that uses Medication Assisted Treatment (MAT) to control withdrawal symptoms of opioid addiction.

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 - A specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the claims administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a licensed mental health care provider for mental health disorders, or a licensed substance use professional for substance use disorders.

Outpatient Care - Services received without being admitted for an inpatient stay. Services received at an ambulatory surgery center are considered outpatient care.

Palliative Care - Services 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 are focused on improving quality of life by enabling a patient to address social, emotional and spiritual needs, 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.

Partial Programs - An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.

Participating Provider - A provider who has entered into 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 (MD), osteopathy (DO), dental surgery (DDS), medical dentistry (DMD), podiatric medicine (DPM), or optometry (OD) practicing within the scope of their license.

Place of Service - Clinic and hospital providers submit claims using national standards established by the Centers for Medicare & Medicaid Services (CMS) and state guidelines. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.

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.

Provider - A health care provider 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/suite infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rapid Whole Genome Sequencing (rWGS) - The investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Rare Disease - a disease or condition that:

1. is chronic, serious, life-altering or life-threatening affecting fewer than 200,000 people in the United States;
2. affects more than 200,000 people in the United States. for which there is a drug that has been designated as a drug for a rare disease or condition pursuant to federal law; and
3. is included on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health or for member or dependent with inconclusive or conflicting lab or clinical test results, had had at least two clinical consultations for the specific complaint, and documentation in their medical record of a developmental delay, developmental regression, failure to thrive, or progressive multisystemic involvement.

A disease or condition that has widely available and known protocols for diagnosis and treatment that is commonly treated in a primary care setting is not a rare disease even if it affects fewer than 200,000 people in the United States.

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 residential treatment under the direction of, a licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care providers. Skilled nursing and medical care are available each day.

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

Retail Health Clinic - A clinic located in a retail establishment. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold).

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

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

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care by, or under the direction of, a doctor of medicine (MD) or osteopathy (DO). A skilled nursing facility provides 24-hour-a-day professional registered nursing (RN) services.

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing their illness, treatment, and the requirements of everyday independent living.

Specialist - A health care provider who limits their 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 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, drugs in specific categories or drug classes. If your health care provider prescribes one (1) of these drugs, there must be documented evidence that you have tried another eligible drug(s) that is safe, more clinically effective, and in some cases more cost-effective before the drug subject to step therapy 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 providers 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 MD, DO, DC, DDS, 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 provider is providing services. Independent contractors are not eligible.

Supplies - Health care materials prescribed by a physician that are not reusable. They are used primarily for a medical purpose and are generally not useful in the absence of illness or injury.

Supplies include, but are not limited to:

1. ostomy supplies;
2. catheters;
3. oxygen; and
4. diabetic supplies.

Surrogate Pregnancy - An arrangement in which a person agrees to carry a pregnancy for another person.

Telehealth Services - The delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a member's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a member located at an originating site and a provider located at a distant site. Originating site means a site where the member is located at the time health care services are provided to the member by means of telehealth. Coverage is provided for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Telehealth does not include communication between providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a provider and a member that consists solely of an e-mail or facsimile transmission.

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 (1) 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). 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, symbols, and trademarks in Minnesota. 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. No person, entity or organization other than the Licensee shall be held accountable or liable to County of Blue Earth Ind School Dist 77 DBA as Mankato ISD for any of the Licensee's obligations under this agreement.