State of Minnesota Retirees Coordinated Plan

Language Access Services

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

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

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

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

နမ့်ကတိၤကသိကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစ၊ၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ်, ကိး 711 တက့၊်.

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

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

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

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

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

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

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

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

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

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

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

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

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

Please note that Blue Cross interprets discrimination based on gender to include discrimination on the basis of sexual orientation and discrimination on the basis of gender identity. Blue Cross does not discriminate, exclude, or treat people differently because of sexual orientation or gender identity.

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

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

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

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

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

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

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

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

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

General Provider Payment Methods

Participating Providers

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

1. 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 charge.

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 member 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.

2. Institutional (i.e., hospital and other facilities)

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 or 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) is 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 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 visit.
- Percentage of Billed Charges. Providers are paid a percentage of their regular billed charges for services.

3. 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.

4. Pharmacy Payment

Generally, four types of pricing are compared, and the lowest amount is paid:

- Average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
- Pharmacy's retail price
- Maximum allowable cost we determine by comparing market prices (for generic drugs only); or,
- Pharmacy's billed charge.

Nonparticipating Providers

When you use a Nonparticipating Provider, benefits are substantially reduced, and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with a Blue Cross 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 Blue Cross 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.

Please refer to “Coverage Information,” “Choosing a Health Care Provider” for additional detail on covered services received from Participating Providers and Nonparticipating Providers.

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
Blue Cross Pays:	80% ($80)	60% ($48)
Coinsurance You Owe:	20% ($20)	40% ($32)
Difference Up to Billed Charge You Owe:	None	$70 ($150 minus $80)
You Pay:	$20	$102

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. For example, some hospital-based providers (for example, anesthesiologists) or laboratory providers may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in some circumstances where you were not able to choose the provider who rendered such care you are not responsible for any amounts above what you would have been required to pay (such as deductibles) had you used a participating provider. You can't be balance billed for emergency services. This includes services you may get after you're in stable condition unless you gave advance written consent to the nonparticipating provider and give up your protections not to be balanced billed for post-stabilization services.

These circumstances could include nonparticipating providers in a participating hospital, your participating physician using a nonparticipating laboratory, post-stabilization following emergency services, or medically necessary air ambulance services. 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 Blue Cross 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, visit bluecrossmn.com/nosurprises.

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 bluecrossmn.com/nosurprises. 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."

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In-network cost sharing for out-of-network services must be applied to your in-network deductible/out-of-pocket maximum.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, 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 isn't in your health plan's network.

Out-of-network providers and facilities that haven't 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 can't 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 an out-of-network provider.

You are protected from balance billing for:

- Emergency services - If you have an emergency medical condition and get emergency services from an out-of-network 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're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. 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 can't balance bill you and may not ask you to give up your protections not to be balance billed.

Ending Surprise Air Ambulance Bills - Air ambulance transportation that is provided to you by out-of-network providers will be reimbursed at in-network cost sharing rates. Out-of-network air ambulance providers can't 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 out-of-network services must be applied to your in-network deductible/out-of-pocket maximum. Please refer to "Ambulance" for coverage of benefits.

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

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

Coverage of Health Care Services on the Basis of Gender

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

Women's Health and Cancer Rights Act

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

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

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

Blue Cross and Blue Shield of Minnesota 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 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 providers in decisions about your treatment;
- give your provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by Blue Cross and its health care providers in accordance with existing law;
- receive information about Blue Cross, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at Blue Cross or at the clinic that you can contact with any concerns about services;
- file a complaint with Blue Cross and the Commissioner of Commerce and receive a prompt and fair review; and,
- initiate a legal proceeding when experiencing a problem with Blue Cross 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 Blue Cross and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your 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.

TABLE OF CONTENTS

INTRODUCTION

State Retiree Coordinated Plan

This certificate is issued and delivered in the state of Minnesota, is subject to the laws of the state of Minnesota, and is not subject to the laws of any other state.

This certificate describes the State Retiree Coordinated Plan (SRCP). For purposes of this certificate, “you” or “your” refers to the group member named on the identification (ID) card. Group member is the person for whom the group contractholder has provided coverage. The group contractholder has contracted with us to provide coverage for its group members. “We,” “us,” and “our” refer to Blue Cross and Blue Shield of Minnesota (Blue Cross). Other terms are defined in the “Definitions” section.

This certificate describes your health care coverage. It replaces all other certificates you have received from us. This certificate explains the Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. It is important that you read this entire certificate carefully. If you have questions about your coverage, please contact us at the address or telephone numbers listed on the “Customer Service” page.

Coverage under this Plan for eligible group members will begin as defined in the “Eligibility” section.

This Plan is a fully insured medical plan. Blue Cross is the insurer and the claims administrator. Coverage is subject to all terms and conditions of this certificate, including medical necessity.

The Plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use Participating Providers. Participating Providers are providers that have entered into a network contract with us to provide you quality health services at favorable prices.

The Plan also provides benefits for covered services you receive from Nonparticipating Providers. In some cases, you receive a reduced level of coverage when you use these providers. Nonparticipating Providers have not entered into a network contract with us. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

IMPORTANT! When receiving care, present your ID card to the provider who is rendering the services.

A copy of our privacy procedures is available on our website at www.bluecrossmn/segip.com or by calling Customer Service.

CUSTOMER SERVICE

Questions?	The Blue Cross customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, admission notification, precertification, or emergency admission notification. Our customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters. Monday-Friday: 7:00 a.m. - 8:00 p.m. United States Central Time *Hours are subject to change without prior notice.*
Customer Service Telephone Number	(651) 662-5090 or toll-free 1-800-262-0819 TDD: (651) 662-8700 or toll-free 1-888-378-0137
Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmn/segip.com
BlueCard Telephone Number	Toll-free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
BlueCard Website	www.bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.

A copy of our privacy procedures is available on our website at www.bluecrossmn/segip.com or by calling Customer Service at the telephone number listed above.

COVERAGE INFORMATION

Choosing a Health Care Provider

You may choose any eligible provider of health services for the care you need. We may pay higher benefits if you choose Participating Providers.

We feature a large network of participating providers, and each provider is an independent contractor and is not our agent.

If you want to know more about the professional qualifications of a specific health care provider, call the provider or clinic directly.

Participating Providers

When you choose these providers, you get the most benefits for the least expense and paperwork. These providers send your claims to us and we send payment to the provider for covered services you receive. The provider directory lists Participating Providers and may change from time to time, at least once a month, including as providers initiate or terminate their network contracts. If you receive a claim for services from a Provider whose status changed from In-Network to Out-of-Network, you may notify us and we will reprocess the claim as an In-Network claim (as long as the Provider accepts our In-Network reimbursement rates and complies with any prior authorization or information requirements), if three criteria are met: (1) the claim is for a service provided after the network status change went into effect but before the change was posted in the online directory; (2) we did not notify you of the network status change before the service was provided; and (3) we are unable to verify that the online directory displayed the correct network status on the date the service was provided. For benefit information, refer to the “Benefit Chart.”

The SRCP covers eligible services when Participating Providers are used. If you choose to use a Nonparticipating Provider, the SRCP still covers eligible services but at a lower payment level. For the highest level of coverage, use Participating Providers. If you reside outside the state of Minnesota or travel world-wide, you need to be aware of your responsibilities when you use a Nonparticipating Provider.

Nonparticipating Providers

Nonparticipating Providers may not take care of notification requirements or file claims for you. You may also pay more of the bill. Refer to the ”Liability for Health Care Expenses” section for a description of charges that are your responsibility.

Liability for Health Care Expenses

Charges That Are Your Responsibility

When you use Participating 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. charges that exceed the benefit maximum;
3. charges for services that are not covered; and,

4. charges for services that are investigative or not medically necessary if you are notified in writing before you receive services that the services are not covered and you agree in writing to pay all charges.

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 us, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full.

You are responsible for payment of any billed charges that exceed the allowed amount. 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. charges that exceed the benefit maximum;
4. charges for services that are not covered including services that we determined are not covered services based on claims coding guidelines

The amount you pay does not apply toward any Out-of-Pocket Maximum contained in the Plan.

Recommendations by Health Care Providers

In some cases, your provider may recommend or provide written authorization for services that are specifically excluded by the Plan. When these services are referred or recommended, a written authorization from your provider does not override any specific Plan exclusions.

Good Faith Estimate of Service Costs

Blue Cross, at your request, will provide a good faith estimate of what a health care service will cost you. When you intend to receive a specific health care service and call Blue Cross for information about how much the service will cost, we will provide a good faith estimate of the allowed amount and your out-of-pocket cost for that service. The good faith estimate applies only to Minnesota resident members and Minnesota Providers. The estimate is not legally binding on Blue Cross. Beginning on July 1st, 2019, we will provide the good faith estimate within 10 business days of receiving all information necessary to provide the estimate.

Fraudulent Practices

Coverage for you will be terminated if you engage in fraud of any type including, but not limited to: submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the Plan to use your coverage.

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.

Medical Policy Committee and Medical Policies

Blue Cross applies medical policies in order to determine benefits consistently for its members. Internally developed policies are subject to approval by our Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a Clinical Psychologist and Pharmacist. The remaining policies are approved by other external specialists. For all policies, Blue Cross' goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time to time new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with Blue Cross' policies in effect at the time Treatment is rendered or, if applicable, prior authorization may be required. Our medical policies can be found at www.bluecrossmn/segip.com. All medical policies are available upon request.

Accommodation Provision

It is the policy of Blue Cross to treat all persons alike, without distinctions based on race, color, religion, national origin, handicap, sex or age. If you have questions about this policy, contact Customer Service at (651) 662-5090 or toll-free 1-800-262-0819. Hearing impaired members with a TDD telephone may contact Customer Services at (651) 662-8700 or toll-free 1-888-878-0137. If you have an impairment that requires alternative communication formats such as Braille, large print or audio cassettes, please request these materials from Customer Service at the telephone numbers listed above. If this Certificate is provided in one of these alternative communication formats, this written version governs all coverage decisions.

NOTIFICATION REQUIREMENTS

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

Prior authorization, admission notification, and precertification are required. If the care you receive is due to a medical emergency, prior authorization is not required.

Emergency admission notification is required within 48 hours of the admission, or as soon as reasonably possible following the admission.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered. The Blue Cross Prior Authorization list describes the services for which Prior Authorization is required. The Prior Authorization list is subject to change due to changes in Blue Cross' medical policy. Blue Cross reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Blue Cross website at bluecrossmn.com/priorauth or call the Customer Service telephone number provided in the "Customer Service" section. They will direct your call. Your prior authorization will be valid through the plan year unless a shorter period is allowed by law. You will be notified if there is a safety or other concern with prior authorized services.

For **inpatient hospital/facility** services, Participating Providers are required to obtain prior authorization for you. You are required to obtain prior authorization when you use Nonparticipating Providers in Minnesota and any provider outside of Minnesota. Some of these providers may obtain Prior Authorization for you. Verify with your providers if this is a service they will perform for you or not.

For **outpatient hospital/facility services or professional services**, Participating Providers are required to obtain prior authorization for you. You are required to obtain prior authorization when you use Nonparticipating Providers and any provider outside of Minnesota. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not.

Minnesota Participating Providers who do not obtain prior authorization are responsible for the charges.

When you use a Nonparticipating Provider, or any provider outside Minnesota, if Prior Authorization is not obtained and if it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.

We require that you or the provider contact us at least 6 working days prior to the provider scheduling the care/services to determine if the services are eligible. We will notify you of our decision within 5 working days after receiving the request, provided that the prior authorization request contains all the information needed to review the service.

Expedited review determination

Blue Cross will use an expedited review determination when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify you as expeditiously as the medical condition requires, but no later than 48 hours from receipt of the initial request or the end of the first business day after receipt of the initial request, whichever comes later, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize Services, you may submit an expedited appeal. See the "Appeal Process" section for more information about submitting an expedited appeal.

We prefer that all requests for prior authorization be submitted to us in writing to ensure accuracy. Please refer to the "Customer Service" section for the telephone number and appropriate mailing address for prior authorization.

Transition of Prior Authorization

If you have an active prior authorization from your prior health plan, we will comply with the approved prior authorization for health care services for at least the first 60 days of your coverage with us. You or your attending health care provider may request transition of a prior authorization by sending us documentation of the previous prior authorization. During the 60-day time period, we will complete a new review of your services following our established prior authorization process.

Notifications

- **Admission notification** is a process whereby the provider, or you, inform us that you will be admitted for inpatient hospitalization services. This notice is required in advance of being admitted for inpatient care for the following type of nonemergency admission. We require that you call us within 48 hours of an admission, or as soon as reasonably possible following the admission.
    - admission notification is required for an admission for normal pregnancy labor and delivery.
- **Emergency admission notification** is a process whereby the provider, or you, inform us within 48 hours of an emergency admission, or as soon as reasonably possible following the admission.

All Minnesota Participating Providers are required to provide notification for you. If those providers do not provide notification for you, then those providers are responsible for the charges.

If you are going to receive care from Nonparticipating Providers, or any provider outside Minnesota, you are required to provide notification to us. Some of these providers may provide notification for you. Verify with your provider if this is a service they will perform for you or not. **For claims from a Nonparticipating Provider or any provider outside Minnesota, if notification is not obtained and if it is found, at the point the claim is**

processed, that services were not medically necessary, you are liable for all of the charges.

You may also be required to obtain prior authorization for the services or procedures while you are inpatient; for instance, if you are having elective surgery while inpatient at a Nonparticipating Provider. Please refer to "Prior Authorization" in this section to determine if you, or your provider, are responsible for obtaining any required Prior Authorization(s).

To provide notification, call the Customer Service telephone number provided in the "Customer Service" section. They will direct your call.

Precertification

Precertification is a process to provide a review and determination related to a specific request for care or services. Precertification includes concurrent/length-of-stay review for inpatient admissions. This notice is required in advance of being admitted for inpatient care for the following types of nonemergency admissions. We require that you or the provider contact us within 48 hours prior to the inpatient admission to determine if the services are eligible.

Precertification is required for the following types of admissions/facilities:

1. Acute medical and acute behavioral health admissions;
2. Acute rehabilitation (ACR) admissions;
3. Long-term acute care (LTAC) admissions;
4. Skilled Nursing Facilities; and,
5. Residential Behavioral Health Treatment Facilities.

Minnesota Participating Providers are required to provide precertification for you. If those providers do not provide precertification for you, then those providers are responsible for the charges.

If you are going to receive nonemergency inpatient care from Nonparticipating Providers, or any provider outside Minnesota, you are required to obtain precertification from us. Some of these providers may obtain precertification for you. Verify with your provider if this is a service they will perform for you or not. **For claims from a Nonparticipating Provider or any provider outside Minnesota, if precertification is not obtained and if it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

You may also be required to obtain prior authorization for the services or procedures while you are inpatient; for instance, if you are having elective surgery while inpatient at a Nonparticipating Provider. Please refer to "Prior Authorization" in this section to determine if you, or your provider, are responsible for obtaining any required Prior Authorization(s).

To provide precertification, call the Customer Service telephone number in the "Customer Service" section. They will direct your call.

Overview

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

Services received from:	Prior Authorization Outpatient	Admission Notification Inpatient	Emergency Admission Notification	Precertification Inpatient
Participating Provider	Participating Provider is responsible to request this for you and the provider must send the request in writing at least 10 working days prior to services.	Participating Provider is responsible for completing the notification and the provider must call within 48 hours of admission or as soon as reasonably possible.	Participating Provider is responsible for completing the notification and the provider must call within 48 hours of admission or as soon as reasonably possible.	Participating Provider is responsible to request this for you and the provider must call within 48 hours prior to admission.
Participating Provider outside of Minnesota	You are responsible for obtaining the prior authorization from Blue Cross and you must send the request in writing at least 10 working days prior to services.	You are responsible for completing the notification to Blue Cross and you must call within 48 hours of admission or as soon as reasonably possible.	You are responsible for completing the notification to Blue Cross and you must call within 48 hours of admission or as soon as reasonably possible.	Participating Provider outside of Minnesota is responsible to request this for you and the provider must call within 48 hours prior to admission.
Nonparticipating Provider	You are responsible for obtaining the prior authorization from Blue Cross and you must send the request in writing at least 10 working days prior to services.	You are responsible for completing the notification to Blue Cross and you must call within 48 hours of admission or as soon as reasonably possible.	You are responsible for completing the notification to Blue Cross and you must call within 48 hours of admission or as soon as reasonably possible.	You are responsible for obtaining the prior approval from Blue Cross and you must call within 48 hours prior to admission.

BENEFIT CHART

This section lists covered services and the benefits that we pay. All benefits are based upon the allowed amounts. Coverage is subject to all terms, conditions, and definitions of this certificate and must be medically necessary. You must notify Blue Cross regarding any discounts, coupons, coupon cards, point of service rebates, debit cards, or other forms of financial arrangements between you and a provider or manufacturer for health care items or medical services (hereinafter referred to as “Coupons”). The dollar amount of any Coupon provided to you by providers or manufacturers will not count toward coinsurance, copayment, or deductible cost-sharing responsibilities or out-of-pocket maximum.
This coverage is not a qualified plan.

Benefit Features, Limitations, and Maximums

Benefit Features	Your Liability
Deductible	
• Coordinated Plan Deductible	$200 per person per calendar year for inpatient hospital/facility charges
Benefit Features	**Limitations and Maximums**
Out-of-Pocket Maximum	
• Inpatient hospital/facility charges	You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
Lifetime Maximum	
• Total benefit paid to all providers combined	Unlimited

Benefit Descriptions

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

AMBULANCE

The Plan Covers:	Benefit Payment
• 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 • Medically necessary and appropriate, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	100%.

NOT COVERED:

- transportation services that are not medically necessary and appropriate for basic or advanced life support
- transportation services that are mainly for your convenience including costs related to transportation to a facility that is not the nearest medical facility equipped to treat the condition
- please refer to the “General Exclusions” section

CHEMICAL DEPENDENCY

The Plan Covers:	Benefit Payment
• Outpatient health care professional charges	100% of the allowed amount.
• Outpatient hospital/outpatient behavioral health facility charges	100% of the allowed amount.
• Inpatient health care professional charges	100% of the allowed amount.
• Inpatient hospital/residential behavioral health facility charges for semi-private room up to 365 days	You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
• Telehealth services	100% of the allowed amount.
• Outpatient health care professional lab	100% of the allowed amount.
• Outpatient health care professional diagnostic imaging	100% of the allowed amount.
• Outpatient hospital/facility lab	100% of the allowed amount.
• Outpatient hospital/facility diagnostic imaging	100% of the allowed amount.
• Inpatient health care professional lab and diagnostic imaging	100% of the allowed amount.
• Inpatient hospital/facility lab and diagnostic imaging	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Coverage is provided for chemical dependency treatment provided to a member by the Department of Corrections while the member is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under Minnesota Statutes Section 169A.24 if:
  - a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes Section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and
  - the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate

medical necessity determination.

- Court-ordered treatment for chemical dependency care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Court ordered treatment 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.

CHEMICAL DEPENDENCY (continued)

NOTES (continued)**:**

- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Based on the federal Mental Health Parity and Addiction Equity Act and Minnesota Statutes, section 62Q.47, members have the right to parity in mental health and substance use disorder treatment. Generally, these laws provide that:
  - mental health and substance abuse services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance abuse services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

  For member questions and concerns please contact Customer Service, or you may file a complaint with Blue Cross, or file a complaint with the Minnesota Department of Commerce.
- The plan covers telehealth services.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.
- The plan covers telemonitoring services when:
  - the telemonitoring service is medically appropriate based on the member's medical condition or status
  - the member is cognitively and physically capable of operating the monitoring device or equipment, or the member has a caregiver who is willing and able to assist with the monitoring device or equipment; and
  - the member resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

NOT COVERED:

- services for chemical dependency that are not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- services to hold or confine a person under chemical influence when no medical services are required
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating chemical

dependency or mental health conditions including, but not limited to: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs

- room and board for foster care, group homes, incarceration, shelter, shelter care and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition
- please refer to the “General Exclusions” section

CHIROPRACTIC CARE

The Plan Covers:	Benefit Payment
• Office visits from a doctor of chiropractic • Manipulations • Therapies • Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy • Other chiropractic services	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Eligible acupuncture services are limited to a maximum of 20 visits per person per calendar year from all providers combined.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs
- services for or related to therapeutic massage
- 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 part of specialized therapy to treat the member's condition
- maintenance services
- custodial care
- please refer to the "General Exclusions" section

DENTAL CARE

The Plan Covers:	Benefit Payment
This is not a dental plan. The following limited dental-related coverage is provided: • Treatment from a physician or dentist for an accidental injury to sound and healthy natural teeth when performed within 12 months from the date of injury	If services apply to: **Inpatient Services:** You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year. **Medical Services:** 100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, certification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- All of the above-mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- The Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The Plan covers surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder on the same basis as any other body joint and administered or prescribed by a Physician or dentist.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- dental services to treat an injury from biting or chewing
- accident-related dental services performed more than 12 months after the date of injury
- dental implants and prosthetics, including any related hospital charges
- osteotomies and other procedures associated with the fitting of dentures or dental implants
- any orthodontia, including associated orthognathic procedures or accident-related dental injuries
- oral surgery and anesthesia for removal of impacted teeth and removal of a tooth root without removal of the whole tooth
- root canal therapy
- tooth extractions, unless otherwise specified as covered
- any other dental procedure or treatment
- services, including dental splints, to treat bruxism
- please refer to the "General Exclusions" section

EMERGENCY CARE

The Plan Covers:	Benefit Payment
• Outpatient health care professional charges to treat an emergency medical condition as defined in Minnesota law	100%
• Outpatient hospital/facility charges to treat an emergency medical condition as defined in Minnesota law	100%

NOTES:

- **Emergency admission notification is required. Please see the "Notification Requirements" section.**
- When determining if a situation is a medical emergency, we will take into consideration presenting symptoms including, but not limited to, severe pain to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, please refer to "Hospital Inpatient" and "Physician Services."
- For urgent care visits, please refer to "Hospital Outpatient" and "Physician Services."
- For additional information about an emergency medical condition, please refer to "Definitions" for a definition of medical emergency.

NOT COVERED:

- please refer to the "General Exclusions" section

GENDER CONFIRMATION CARE

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

The Plan Covers:	**Benefit Payment**
Outpatient health care professional services including: • Office visit • Counseling	100% of the allowed amount
Professional services for gender affirming procedures for the treatment of gender dysphoria	100% of the allowed amount

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Services include related preparation and follow-up treatment care.
- Gender confirming care for the treatment of gender dysphoria may include surgical procedures, such as breast/chest, genital, facial, thyroid cartilage reduction, and voice, as well as non-surgical procedures and treatments such as voice therapy, hair removal, and hormone therapy. These services are covered when they are medically necessary and appropriate for the treatment of gender dysphoria including meeting medical policy criteria where applicable.
- Gender-specific preventive services are covered for transgender persons appropriate to their anatomy. For preventive care services, please refer to "Preventive Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For prescription drugs for the management of gender dysphoria, please refer to "Prescription Drugs."
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

- For therapeutic injections, please refer to “Hospital Outpatient Care” or “Office Visit and Professional Services.”
- For more information contact Customer Service or visit bluecrossmn.com/gendercare.

GENDER CONFIRMATION CARE (continued)

NOT COVERED:
- Treatment, services, or supplies that are not medically necessary.

HOME HEALTH CARE

The Plan Covers:	Benefit Payment
• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare or Plan approved home health care agency including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services of a home health aide or master's level social worker employed by the home health care agency when provided in conjunction with services provided by the above-listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care visit following early maternity discharge	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Benefits for home infusion therapy and related home health care are listed under "Home Infusion Therapy."
- For supplies and durable medical equipment billed by a Home Health Agency, please refer to "Medical Equipment, Prosthetics, and Supplies."
- Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other preapproved home health care agency consists of up to two (2) consecutive hours per date of service.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- charges for or related to care that is custodial in nature (please refer to "Custodial Care," “Skilled Nursing Care – Intermittent Hours,” "Skilled Nursing Care – Extended Hours,” and “Skilled Care” in the "Definitions" section)
- treatment, services or supplies which are not medically necessary
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law (please refer to “Extended Hours Skilled Nursing Care” in the “Definitions” section)
- please refer to the “General Exclusions” section

HOME INFUSION THERAPY

The Plan Covers:	Benefit Payment
• Home infusion therapy services, when ordered by a physician • Durable medical equipment • Ancillary medical supplies • Nursing services to: ▪ train you or your caregiver ▪ monitor the home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- home infusion services or supplies not specifically listed as covered services
- nursing services to administer home infusion therapy when the patient or another caregiver can be successfully trained to administer therapy
- services that do not involve direct patient contact, such as delivery charges and record keeping
- investigative or non-FDA approved drugs
- please refer to the "General Exclusions" section

HOSPICE CARE

The Plan Covers:	Benefit Payment
• Hospice care for a terminal condition provided by a Medicare-approved hospice provider or other preapproved hospice including: ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care	100% of the allowed amount.

NOTES:

- Benefits are restricted to patients with a terminal condition (i.e., life expectancy of six (6) months or less). The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered but are separate from the hospice benefit.
- Two (2) or more episodes of hospice care will be considered one (1) episode unless separated by a period of at least three (3) months during which no hospice program is in effect for the individual.
- You must agree to waive the standard benefits under the certificate, except when medically necessary because of an illness or injury unrelated to the terminal diagnosis.

NOT COVERED:

- services you receive from a Nonparticipating Provider
- room and board expenses in a residential hospice facility
- please refer to the "General Exclusions" section

HOSPITAL INPATIENT

The Plan Covers:	Benefit Payment
• Room and board up to 365 days 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 • Telehealth services • Lab • Diagnostic imaging	You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
• Communication services of a private duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons	100% of the allowed amount. No deductible applies.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- The Plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant or other kinds of transplants, please refer to "Transplant Coverage."
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and,
  - hospital and professional services related to organ procurement.
- The Plan covers anesthesia and inpatient hospital charges when necessary to provide dental to a covered person who 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.
- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
  - Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."

NOTES (continued)**:**

- Under federal law, the Plan may require that a provider obtain authorization from the Plan for the portion of a stay after the 48 hours or 96 hours, mentioned above.
- The plan covers telehealth services.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- travel expenses for a kidney donor
- complications incurred by a kidney donor after the organ is removed
- kidney donor expenses when the recipient is not covered for the kidney transplant under this certificate
- communication services provided on an outpatient basis or in the home
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law
- please refer to the “General Exclusions” section

HOSPITAL OUTPATIENT

The Plan Covers:	Benefit Payment
• Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational, and speech therapy • Lab • Diagnostic imaging • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Urgent care • Facility billed services received at a free-standing ambulatory surgical center • Prenatal and postnatal care • Telehealth services • All other eligible outpatient hospital care	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- The Plan covers anesthesia and outpatient hospital charges when necessary to provide dental to a covered person who is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The Plan covers 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.
- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
  - Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."

NOTES:

- Under federal law, the Plan may require that a provider obtain authorization from the Plan for the portion of a stay after the 48 hours or 96 hours, mentioned above.
- The plan covers telehealth services.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.
- Prenatal care – 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.
- Postpartum care – comprehensive postnatal visits to provide a full assessment of the 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.

NOT COVERED:

- please refer to the “General Exclusions” section

MEDICAL EQUIPMENT, PROSTHETICS, AND SUPPLIES

The Plan Covers:	Benefit Payment
• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds • Devices for habilitative and rehabilitative services • Medical supplies, including splints, surgical stockings, casts, and dressings • Insulin pumps, glucometers and related equipment and devices not otherwise covered under the Medicare Part D program • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for phenylketonuria (PKU) when recommended by a physician • Amino acid-based elemental formula • All Physician prescribed medically necessary diabetic supplies not otherwise covered under the Medicare Part D program • Corrective lenses for aphakia • Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per person per calendar year. • Custom foot orthoses if you have a diagnosis of diabetes with neurological manifestations of one or both feet • Blood/urine test strips or syringes/needles which are purchased separately from insulin for SRCP Members who used such supplies between January 1, 1991 and September 30, 1991 (see Prescription Drugs, Section C.16)	100% of the allowed amount.

• Hearing aids, batteries and accessories are eligible if purchased through a provider or hearing aid supplier who participates with Blue Cross up to a benefit limitation of once every three (3) years	80% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Durable Medical Equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- Hearing aids and hearing aid evaluation tests, which are to determine the appropriate type of aid are covered up to a benefit limitation of once every three (3) years.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart"
- personal and convenience items or items provided at levels which exceed our determination of medically necessary
- services or supplies that are primarily and customarily used for a nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants
- modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- foot orthoses, except as provided in this "Benefit Chart"
- 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 in this "Benefit Chart"
- duplicate equipment, prosthetics

NOT COVERED (continued)**:**

- replacement of properly functioning durable medical equipment
- devices for maintenance services
- please refer to the “General Exclusions” section

MENTAL HEALTH CARE

The Plan Covers:	Benefit Payment
• Outpatient health care professional charges	100% of the allowed amount.
• Outpatient hospital/outpatient behavioral health facility charges	100% of the allowed amount.
• Inpatient health care professional charges	100% of the allowed amount.
• Inpatient hospital/ residential behavioral health facility charges for semi-private room up to 365 days	You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
• Telehealth services	100% of the allowed amount.
• Outpatient health care professional lab	100% of the allowed amount.
• Outpatient health care professional diagnostic imaging	100% of the allowed amount.
• Outpatient hospital/facility lab	100% of the allowed amount.
• Outpatient hospital/facility diagnostic imaging	100% of the allowed amount.
• Inpatient health care professional lab and diagnostic imaging	100% of the allowed amount.
• Inpatient hospital/facility lab and diagnostic imaging	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Coverage is provided for chemical dependency treatment provided to a member by the Department of Corrections while the member is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under Minnesota Statutes Section 169A.24 if:
    - a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes Section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and
    - the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department

that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination.

- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this plan.
- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.

NOTES (continued)**:**

- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Benefits are provided for autism treatment including intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.
- Based on the federal Mental Health Parity and Addiction Equity Act and Minnesota Statutes, section 62Q.47, members have the right to parity in mental health and substance use disorder treatment. Generally, these laws provide that:
  - mental health and substance abuse services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance abuse services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

  For member questions and concerns please contact Customer Service, or you may file a complaint with Blue Cross, or file a complaint with the Minnesota Department of Commerce.
- The plan covers telehealth services.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.
- Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
- The plan covers telemonitoring services when:
  - the telemonitoring service is medically appropriate based on the member's medical condition or status
  - the member is cognitively and physically capable of operating the monitoring device or equipment, or the member has a caregiver who is willing and able to assist with the monitoring device or equipment; and
  - the member resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

NOT COVERED:

- services for mental illness not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating mental health or chemical dependency conditions including, but not limited to: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs
- room and board for foster care, group homes, shelter care, and lodging programs
- halfway house services
- court-ordered services that are not medically necessary
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars
- services for marriage/couples counseling
- educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- therapeutic day care and therapeutic camp services
- hippotherapy (equine movement therapy)
- please refer to the “General Exclusions” section

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	Benefit Payment
• Office visits from a physical therapist, occupational therapist, speech or language pathologist • Therapies • Office visits from a physician - see "Physician Services"	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services primarily educational in nature, except as specified in the "Benefit Chart"
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs
- services for or related to therapeutic massage
- 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 part of specialized therapy for the member's condition
- maintenance services
- custodial care
- please refer to the "General Exclusions" section

PHYSICIAN SERVICES

The Plan Covers:	Benefit Payment
• Office visit for illness • Office visit for Urgent care services • E-Visit • Telehealth services • Retail Health Clinic visit • Office and outpatient lab • Office and outpatient diagnostic imaging • Allergy testing, serum, and injections not otherwise covered under the Medicare Part D program • Eligible vaccines administered in the clinic (i.e., shingles, flu, etc.) • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization • Assistant surgeon • Medically necessary services of a Registered Nurse First Assistant • Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon • Kidney and cornea transplants • Hearing exams, audiometric tests, and audiologist evaluations which are provided by a participating Audiologist or Otolaryngologist • Palliative care	100% of the allowed amount.

• Prenatal and postnatal care • Acupuncture services for the treatment of chronic pain, nausea associated with surgery, chemotherapy or pregnancy	

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- If more than one (1) surgical procedure is performed during the same operative session, Blue Cross covers the surgical procedures based on the allowed amount for each procedure. Blue Cross does not cover a charge separate from the surgery for pre-operative and post-operative care billed by a Nonparticipating Provider.
- Physician services includes services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- You are entitled to receive care for the following services from providers who are not affiliated with Blue Cross:
  - the testing and treatment of a sexually transmitted disease; and,
  - the testing of AIDS or other HIV-related conditions.
- For kidney transplants done in conjunction with an eligible major transplant, please refer to "Transplant Coverage."
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and,
  - hospital and professional services related to organ procurement.
- The Plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Eligible acupuncture services are limited to a maximum of 20 visits per person per calendar year from all providers combined.
- The Plan covers hearing aid exams/fitting/adjustments.
- 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.
- E-Visit is a patient initiated, limited online evaluation and management service provided by a physician or other qualified health care Provider using the Internet or similar secure communications network to communicate with an established patient.
- The plan covers telehealth services.

NOTES (continued)**:**

- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
- Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
- Under federal law, the Plan may require that a provider obtain authorization from the Plan for the portion of a stay after the 48 hours or 96 hours, mentioned above.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.
- The plan covers telemonitoring services when:
- the telemonitoring service is medically appropriate based on the member’s medical condition or status
- the member is cognitively and physically capable of operating the monitoring device or equipment, or the member has a caregiver who is willing and able to assist with the monitoring device or equipment; and
- the member resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.
- Eligible therapeutic 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 and the medication are billed by the health care provider are eligible under the "Physician Services" benefit. For therapeutic injectable medications billed by a pharmacy, please refer to "Prescription Drugs.” Therapeutic drugs includes coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- Prenatal care – 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.
- Postpartum care – comprehensive postnatal visits to provide a full assessment of the 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.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- separate charges for pre-operative and post-operative care for surgery billed by a Nonparticipating Provider
- services for or related to cosmetic health services or surgery and related services, and treatment for conditions or ptoblems related to cosmetic surgery or services, except as specified in the "Benefit Chart"
- internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- Nonparticipating Provider initiated email communications
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- please refer to the “General Exclusions” section

PRESCRIPTION DRUGS AND INSULIN

Outpatient prescription drug coverage is provided through Group MedicareBlue Rx. Please refer to your MedicareBlue Rx information for details.

This health care plan does provide benefits for eligible drugs administered during a covered admission to an eligible inpatient facility when billed by that facility. Please refer to “Hopsital Inpatient.”

PREVENTIVE CARE

The Plan Covers:	Benefit Payment

• Preventive medical evaluation
• Gynecological exams
• Vision exams (glaucoma, acuity, refraction)
• Cancer screening as specified below:
  ▪ mammograms, 2 dimensional (2-D) or 3 dimensional (3-D) for annual screening, including members with a previous history of breast cancer
  ▪ pap smears
  ▪ flexible sigmoidoscopies and/or colonoscopies
  ▪ fecal occult blood testing
  ▪ Prostate Specific Antigen (PSA) tests and digital rectal exams for men of all ages
  ▪ surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam)
• Standard immunizations not otherwise covered under the Medicare Part D program
• Hearing screening
• Osteoporosis screening
• Lab services as specified below:
  ▪ lipid profile, including total and HDL cholesterol
  ▪ diabetes screening
  ▪ screening for chlamydia, gonorrhea, syphilis and HIV
	100% of the allowed amount.

NOTES:

- Benefits for services identified as Preventive Care are determined based on recommendations and criteria established by professional associations and experts in the field of Preventive Care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP)).
- Eligible standard immunizations (e.g., diphtheria, tetanus) are covered under the Preventive Care benefit based on recommendations and criteria established by professional associations and experts in the field of Preventive Care.
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Please refer to "Hospital Inpatient," "Hospital Outpatient," and "Physician Services" for appropriate benefit levels.

PREVENTIVE CARE (continued)

NOTES (continued)**:**

- Benefits for physical exams are limited to one (1) per person per calendar year. Cancer screening services are not subject to the calendar year maximum.
- Benefits for gynecological exams are limited to one (1) per person per calendar year. Cancer screening services are not subject to the calendar year maximum.
- Benefits for hearing screening are limited to one (1) per person per calendar year.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third-party request
- educational classes or programs
- services for or related to lenses, frames, contact lenses and other fabricated devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Benefit Chart"
- please refer to the “General Exclusions” section

RECONSTRUCTIVE SURGERY

The Plan Covers:	Benefit Payment
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the body part • Elimination or maximum feasible treatment of port wine stains	100% of the allowed amount.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- For hospital/facility charges, please refer to "Hospital Inpatient" and "Hospital Outpatient."
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- please refer to the "General Exclusions" section

SKILLED NURSING FACILITY

The Plan Covers:	Benefit Payment
• Skilled care ordered by a physician • Room and board up to 365 days • General nursing care • Physical, occupational, and speech therapy	You are responsible for the $200 annual deductible and 20% of the first $3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.

NOTES:

- **Prior authorization, admission notification, precertification, or emergency admission notification are required. Please see the "Notification Requirements" section.**
- Skilled care ordered by a physician includes skilled care ordered by an optometrist, chiropractor, or advanced practice nurse when ordered within the scope of their licensure.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the "General Exclusions" section

TRANSPLANT COVERAGE

The Plan Covers:	Blue Distinction Centers for Transplant (BDCT) Providers	Non-Blue Distinction Centers for Transplant (BDCT) Providers
The following medically necsesary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart-lung • Liver • Liver-kidney • Lung	100% of the Transplant Payment Allowance. Coordinated Plan deductible does not apply. If you live more than 50 miles from a BDCT Provider, there may be benefits available for expenses directly related to a preauthorized transplant. 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.	*Participating Transplant Provider* 80% of the allowed amount. 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. *Nonparticipating Transplant Provider* **NO COVERAGE.**

NOTES:

- Kidney transplants when not done in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to “Hospital Inpatient” and “Physician Services.”
- Prior authorization must be obtained before a transplant procedure.
- For information about benefits available for expenses directly related to a preauthorized transplant, call Customer Service at the number on the back of your ID card.

NOT COVERED:

- travel benefits when you are using a Non-BDTC Provider
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs and aftercare for or related to human organ transplants not specifically listed above as covered
- Services for or related to transplant, including chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures, that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this Plan
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- please refer to the “General Exclusions” section

DEFINITIONS:

- *BDCT Provider* means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers 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. Once selected for participation, institutions are re-evaluated annually to ensure that they continue to meet the established criteria for participation in this network.
- *Participating Transplant Provider* means a hospital or other institution that has a contract with Blue Cross and Blue Shield of Minnesota or with their local Blue Cross and/or Blue Shield Plan to provide human organ, bone marrow, cord blood, and peripheral stem cell support procedures.
- *Transplant payment allowance* means the amount the Plan pays for covered services to a BDCT Provider or a Participating Transplant Provider for services related to human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures in the agreement with that provider.

* An association of independent Blue Cross and Blue Shield Plans.

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatments, services, or supplies which are not medically necessary.

2. Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.

3. Services that are normally provided without charge, including services of the clergy.

4. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while your coverage was in force.

5. Services for or related to acupuncture except for Medically Necessary and Appropriate acupuncture services for the treatment of chronic pain (defined as duration of at least six (6) months); and for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy (these exceptions are limited to 20 visits per person per Calendar year from all providers combined).

6. Acupuncture Services related to the prevention and Treatment of nausea associated with surgery, chemotherapy, or pregnancy where the patient's symptoms are neither regressing nor improving, are not Medically Necessary and are considered Maintenance Services.

7. Claims for the treatment of an employment-related injury for claims paid under a workers' compensation claim unless the worker's compensation carrier has disputed the claim. This certificate will still cover eligible services that are provided to you that are not paid by worker's compensation coverage for the treatment of an employment related illness/injury.

8. Services a provider gives to himself/herself or to a close relative (such as a spouse, brother, sister, parent, grandparent, and/or child).

9. To the extent benefits are provided to members of the armed forces while on active duty or to members in Services for or related to treatment of illness or injury which occurs while on military duty that are recognized by the Veteran's Administration as services related to facilities for service connected illnesses/injuries, unless you have an obligation to pay.

10. Charges for services for dependents. This is individual coverage only.

11. Services that are prohibited by law or regulation. If you have questions regarding how this exclusion applies to your benefits, please contact us by calling the Customer Service telephone number provided in the "Customer Service" section.

12. Services which are not within the scope of licensure or certification of a provider.

13. Charges for furnishing medical records or reports and associated delivery charges billed by a Nonparticipating Provider.

14. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in “Ambulance.”

15. Travel, transportation, or living expenses, whether or not recommended by a physician, except for travel expenses and ambulance transporation listed as covered in the benefit charts.

16. Services for or related to chemical dependency or addictions that are not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

17. Court ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as specified under Minnesota law.

18. Evaluations that are not performed for the purpose of diagnosing or treating chemical dependency or mental health conditions including, but not limited to: custody evaluations, parenting assessments, education classes, classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.

19. Services for or related to room and board for foster care, group homes, shelter, shelter care, incarceration and lodging programs, halfway house services, and skills training.

20. Charges submitted by a health care professional for unscheduled physician/patient telephone calls initiated by the physician.

21. Services for or related to chemical dependency 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.

22. Dentures, regardless of the cause or condition, and any associated services and/or charges, including bone grafts.

23. Dental implants and dental prosthetics including any associated services and/or charges.

24. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in "Dental Care."

25. Services, including dental splints, to treat bruxism.

26. Room and board expenses in a residential hospice facility.

27. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy.

28. Services that do not involve direct patient contact such as delivery charges and recordkeeping billed by a Nonparticipating Provider.

29. Admission for diagnostic tests that can be performed on an outpatient basis.

30. Service for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except noted in the Hospital Inpatient and Home Health Care benefit charts.

31. Personal comfort items, such as telephone, television, etc.

32. Communication services provided on an outpatient basis or in the home.

33. Services for or related to reversal of sterilization.

34. Services or supplies that are primarily and customarily used for 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.

35. Modifications to home, vehicle and/or the workplace, including vehicle lifts and ramps.

36. Blood pressure monitoring devices.

37. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.

38. Services for or related to mental illness not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

39. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic famiily environment or support for the foster child's improved functioning); the treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

40. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

41. Services for or related to marriage/couples counseling.

42. Services for educational classes or programs, except for nutritional education for anorexia nervosa, bulimia or eating disorders; diabetes out-patient self-management training and education.

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

44. Physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.

45. Services for or related to health clubs and spas.

46. 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 necsesary and part of a specialized therapy for the member's condition.

47. Maintenance services.

48. Custodial care.

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

50. Service for or related to therapeutic massage.

51. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.

52. Services for or related to the repair of scars and blemishes on skin surfaces, except as noted in the Restructive Surgery benefit chart.

53. 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.

54. Nonparticipating Provider initiated email communications.

55. Services provided during a Telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal /medical test results; providing educational materials; updating patient information; requesting a referral; and, additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.

56. Services for or related to gene therapy (for those considered experimental) as a treatment for inherited or acquired disorders.

57. Services for or related to growth hormone except that replacement therapy is eligible for conditions that meet medical necessity criteria as determined by us prior to receipt of the services.

58. Autopsies.

59. Charges for failure to keep scheduled visits.

60. Charges for giving injections which can be self-administered.

61. Services for or related to tobacco cessation program fees and/or related program supplies.

62. Services for or related to commercial weight loss programs, fees or dues, nutritional supplements, food, vitamins and exercise therapy, and all associated labs, physician visits, and services related to such programs.

63. Treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy or chelation therapy that are not medically necessary.

64. Nonprescription (over-the-counter) and outpatient drugs or medicines, vitamin therapy or dietary supplements; and investigative or non-FDA approved drugs.

65. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

66. 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 specified in “Reconstructive Surgery” or for circumstances that meet the definition of medical emergency.

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

68. services for or related to transplant, including chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures, that are considered investigative or not medically necessary.

69. Services for or related to fetal tissue transplantation.

70. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this certificate; and kidney donor expenses when the recipient is not covered under this certficate.

71. 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.

ELIGIBILITY

The Minnesota Management and Budget (MMB) determine the eligibility subject to collective bargaining agreements, which may change during a benefit year. Blue Cross agrees to accept the decisions of the MMB as binding. This is individual only coverage.

Effective Date of Coverage

The effective date of coverage is determined by the MMB.

Termination of Coverage

Coverage ends on the earliest of the following dates:

1. the end of the month in which either Blue Cross or the MMB terminates the Contract;
2. the end of the month in which eligibility under the Contract ends; or,
3. the end of the month for which the last full premium was paid, when the member fails to pay the premium within 30 days of the date the premium is billed or is due, whichever is later.

Extension of Benefits

If you are confined as an inpatient on the date your coverage ends due to the replacement of the group contract, we automatically extend coverage until the date you are discharged from the facility or the date contract 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 group contract terminates and the group contractholder obtains continuous group coverage with a new carrier.

Off-Cycle Enrollment Without Evidence of Insurability

A member will be allowed to make an enrollment choice outside of the open enrollment period or initial period of eligibility without evidence of insurability under any of the circumstances specified below. Decisions as to whether these circumstances occur are at the sole discretion of the MMB and are binding on Blue Cross.

1. Any carrier participating in the State Employee Group Insurance Program is placed into rehabilitation or liquidation or is otherwise unable to provide the services specified in the certificate and/or benefit booklet.
2. Any carrier participating in the State Employee Group Insurance Program loses all or a portion of its primary care provider network (including hospitals) to the extent that services are not accessible or available within thirty miles of the workstation, including withdrawal from an approved service area.
3. The Carrier participating in the State Employee Group Insurance Program terminates or is terminated from participation in the Program.
4. The MMB approves a request from an employee or an agency due to a breakdown in the open enrollment process.
5. A member may elect to designate another carrier in the 60-day time period immediately preceding the effective date of retirement.
6. As otherwise specified by the MMB.

COORDINATION OF BENEFITS

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

Definitions

These definitions apply only to this section.

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

   a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage (group coverage is always primary and pays first);

   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 that provides health care benefits.

3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

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

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

   Notes:
   a. If you are covered under This Plan and Medicare: This Plan will comply with the Medicare Secondary Payor (“MSP”) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. Medicare will be primary, and this Plan will be secondary only to the extent permitted by MSP rules.

b. If you are covered under This Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. TRICARE will be primary, and This Plan will be secondary only to the extent permitted by TRICARE rules.

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.

   The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under this Plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

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

Order of Benefits Rules

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

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

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

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

   a. Active/inactive employee. The plan that covers a person as an employee who is neither laid off nor retired determines benefits before a plan that covers that person as a laid-off or retired employee. If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.

   b. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

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

Effect on Benefits of This Plan

1. When this section applies.

   When the Order of Benefits Rules above requires this Plan to be a secondary plan, this part applies. Benefits of this Plan may be reduced.

2. Reduction in this Plan’s benefits.

   The benefits that would be payable under this 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 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 Plan are reduced each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

   If you are eligible to have Medicare pay as your primary health plan, payment under This Plan will be reduced by the amounts Medicare Parts A and B paid or would have paid for covered services.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. Blue Cross has the right to decide which facts are needed. Blue Cross may get needed facts from, or give them to, any other organization or person as necessary to coordinate benefits under this certificate. Blue Cross does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Blue Cross any facts needed to pay the claim.

Facility of Payment

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

Right of Recovery

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

1. the persons it paid or for whom it has paid;
2. insurance companies; or,
3. other organizations.

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

REIMBURSEMENT AND SUBROGATION

If Blue Cross pays benefits for medical or dental expenses you incur as a result of any act of any person, and you later obtain full compensation, you are obligated to reimburse Blue Cross for the benefits paid. If you receive benefits under this Plan arising out of illness or injury for which a responsible party is or may be liable, we are also entitled to subrogate against any person, corporation and/or other legal entity, or any insurance coverage, including both first- and third-party automobile coverages to the full extent we provided any benefits. Unless we are separately represented by our own attorney, our right to reimbursement and subrogation is subject to you obtaining full recovery, as explained in Minnesota statutes 62A.095 and 62A.096. Our right to subrogation and reimbursement is subject to reduction for first, our pro rata share of costs, disbursements, and then reduced by reasonable attorney fees incurred in obtaining the recovery. For the 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 Blue Cross is separately represented by an attorney, Blue Cross and the covered member, by their attorneys, may enter into an agreement regarding allocation of the covered member's cost, disbursements, and reasonable attorney fees and other expenses. If Blue Cross and the covered member cannot reach agreement on allocation, Blue Cross and the covered member shall submit the matter to binding arbitration.

Notice Requirement

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

Duty to Cooperate

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

Filing a Claim and Review Procedure

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 us of a claim we will send you a claim form within 15 days. Claim forms are also available by calling the toll-free Customer Service telephone number listed in the Customer Service section and on our website at www.bluecrossmn/segip.com. You can also write us at the address listed in the Customer Service section. You must file a written claim within 30 days after a covered service is provided. If this is not reasonably possible, we accept claims for up to 12 months after the date of service. Normally, failure to file a claim within the required time limits will result in denial of your claim. We waive these limits, however, if you cannot file the claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

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

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

Right of Examination

Blue Cross has the right to ask you to be examined by a provider during the review of any claim. Blue Cross will choose the provider and pay for any such exam. Failure to comply with this request may result in denial of your claim.

Release of Records

By your application, you have agreed to allow all providers to give us needed information about the care they provide to you. This includes information about care received prior to my enrollment with Blue Cross, where necessary. We may need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but we may release it if you authorize release, or if state or federal law permits or requires release without your authorization. If a provider requires special authorization for release of records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Entire Contract

This Certificate, including the endorsements and attached papers if any, the employer application, the employee enrollment form, the ID card, application, and the group contract make up the entire Contract of Coverage. You may ask to see the Group Contract at the Employer's office. This certificate is issued and delivered in the state of Minnesota. It is subject to the substantive laws of the state of Minnesota, without regard to its choice of law principles; and it is not subject to the substantive laws of any other state.

Discretionary Authority

Blue Cross has discretionary authority to determine your eligibility for benefits and to construe the provisions of the Contract and this certificate. All statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the contract, unless it is contained in the written application.

Time Limit for Misstatements

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

Changes to the Group Contract

All changes to the Group Contract must be approved by MMB and attached to the Group Contract. The MMB may add/change eligible classes of employees from time to time, and such changes will be noted in the Group Contract. No agent can legally change the Group Contract or waive any of its terms.

In applying any Deductible or waiting period, Blue Cross gives credit for the full or partial satisfaction of the same or similar provisions under the prior contract.

Whom We Pay

When you receive Covered Services from Participating Providers, Blue Cross pays the Provider directly. When you receive Covered Services from a Nonparticipating Provider, Blue Cross pays you. You may not assign your benefits to a Nonparticipating Provider. This provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and certain out-of-state institutional and medical/surgical providers.You also may not assign your right, if any, to commence legal proceedings against Blue Cross.

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

No Third-Party Beneficiaries

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

Legal Actions

No action at law or in equity shall be brought to recover on this plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this plan. No legal action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Plan Change

Nothing in the contract between the state of Minnesota and Blue Cross shall modify, limit or restrict the authority of the Commissioner of MMB as permitted by law to enter into contracts with other carriers or Providers; to remove a health plan from the State Employee Group Insurance Program; and to limit the geographic area serviced by the health plan covering members under the State Employee Group Insurance Program.

Payment of Premiums

Premiums for your coverage must be prepaid.

We have the right to change the rate for all contracts like yours and will notify you in advance of any changes.

Grace Period

After your first payment of premiums, we allow a 90-day grace period for payment. The grace period starts on the day after the due date for payment. You are covered during this grace period provided payment of premiums is made by the end of the grace period. If we do not receive payment by the end of the grace period, your contract will be terminated retroactively to the first of the month following the date to which coverage has been paid.

APPEAL PROCESS

Introduction

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

You can call or write us with your appeal. We will send an appeal form to you upon request. If you need assistance, we will complete the written appeal form and mail it to you for your signature. We will work to resolve your complaint 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 651-539-7600 or toll-free 1-800-657-3602. If you are covered under a Plan offered by the State Health Plan, a city, county, school district, or Service cooperative, you may also contact the U.S. Department of Health and Human Services Insurance Assistance Team at 888-393-2789.

Definitions

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

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

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

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

First Level Appeals that do not Require a Medical Determination

First Level Oral Complaint

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

your appeal, and you must identify and provide all evidence in support of your appeal unless that evidence is already in our possession.

First Level Written Appeals

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

We will inform you of our decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you in advance of the reasons for the extension. You have the right to review the information that we relied on in the course of the appeal.

First Level Appeals That Require a Medical Determination

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

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

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

Definitions

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

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

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

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

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

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

Standard First Level Appeal

You or your Attending Health Care Provider may appeal Blue Cross' initial determination to not certify Services in writing or by telephone. The decision on this first level appeal will be made by a Health Care Provider who did not make the initial determination. We will notify you and your Attending Health Care Provider of our decision within 15 days of receipt of your appeal. If we are unable to make a decision within 15 days due to circumstances outside our control, we may take up to 4 additional days to make a decision. If we take more than 15 days to make a decision, we will inform you of the reasons for the extension. You have the right to review information relied on in making the initial determination.

Expedited First Level Appeal

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

Second Level Appeals to Blue Cross Internal Appeals Committee

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

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

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

- any other information you believe will be helpful to the decision maker

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

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

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

External Review

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

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

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
Suite 280
85 7th Place East
St. Paul, Minnesota 55101-2198
651-539-1600 or toll free 1-800-657-3602

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

Expedited External Review

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

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

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

DEFINITIONS

Please refer to the Benefit Chart for specific benefits and payment information.

Accountable Care Organization (ACO)

A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

Admission

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

Advanced Practice Nurses

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

Allowed Amount

The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as provided in the “Benefit Chart.” The allowed amount may include the provider’s applicable taxes, for example, the MinnesotaCare Tax.

For participating providers, the allowed amount is the negotiated amount of payment that the network provider has agreed to accept as full payment for a covered service at the time your claim is processed. We periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at network providers as a result of expected settlements or other factors. The negotiated amount of payment with network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, which may include an agreed upon fee schedule rate, case rate, withhold and or/capitation agreements, rebates, prospective payments or other methods, we may adjust the amount due to network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to us, and the percentage of the allowed amount paid by us is lower than the stated percentage for the covered service. If the payment to the provider is increased, we pay that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The Allowed Amount for All Nonparticipating Providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. Blue Cross will pay the stated percentage of the allowed amount for a covered service. In

most cases, Blue Cross will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in our Provider Policy and Procedure Manual. As a result, we may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The Allowed Amount for Nonparticipating Providers in Minnesota

For nonparticipating provider services within Minnesota, except those described in "Special Circumstances," the allowed amount will be based upon one of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage 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 Blue Cross may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Cross.

The Allowed Amount for All 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 of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage 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 Blue Cross may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Cross.

Approved Clinical Trial

An approved phase I, phase II, phase III or phase IV clinical trial conducted to prevent, detect or treat cancer or a life-threatening condition and is not designed solely to test toxicity or disease pathophysiology. To be an approved clinical trial, it must be: (i) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; (ii) exempt from obtaining an investigational new drug application; or (iii) approved or funded by certain government entities and their partners, or nongovernment entities operating under government guidelines.

Attending Health Care Professional	A health care professional with primary responsibility for the care provided to a sick or injured person.
Audiologist	A person who has a certificate of clinical competence in audiology from the American-Speech-Language-Hearing Association.
Audiologist Evaluation	A hearing test and an assessment by a licensed audiologist or otolaryngologist of communication problems caused by hearing loss.
Average Semiprivate Room Rate	The average rate charged for semiprivate rooms. If the Provider has no semiprivate rooms, we use the average private room rate for payment of the claim.
Behavioral Health Network Provider	A health care professional that participates in a special network for the provision of mental health or chemical dependency treatment services.
Benefit Chart	The schedule that lists benefit and covered services.
Calendar Year	The period starting on January 1st of each year and ending at midnight December 31st of that year.
Care/Case Management Plan	A plan for health care services developed for a specific patient by one of our care/case managers after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain optimal health status.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.
Certification of Coverage	A form which will be issued when health coverage is terminated under the certificate. This Certification of Coverage form will contain the necessary information a new health plan will need to apply the appropriate credit toward the new health plan's preexisting condition limitation period.
Chemical Dependency	Alcohol or drug dependence as defined in the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Claim

A claim is a written submission from your provider (or from you when you use Nonparticipating Providers) to us. Most claims are submitted electronically. The claim tells us what services the provider delivered to you. In some cases, we may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to us promptly. If the provider delivered a service that is a non-covered benefit, the claim will deny, meaning no payment is allowed.

Providers are required to use certain codes to explain the care they give you. The provider's medical record must support the codes being used. We may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to talk to your provider.

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 maximum. For covered services from Participating Providers, coinsurance is calculated based on the lesser of the allowed amount or the Participating Provider’s billed charge. Because payment amounts are negotiated with Participating Providers to achieve overall lower costs, the allowed amount for Participating Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for Participating Providers, the percentage of the allowed amount paid by Blue Cross will be greater than the stated.

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 Blue Cross 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 and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements Blue Cross 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 Blue Cross' allowed amount when a Nonparticipating Provider is used.

For example, if a Nonparticipating Provider ordinarily charges $100 for a service, but Blue Cross' 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.

Comprehensive Pain Management Program

A multidisciplinary program including, at a minimum, the following components:

1. a comprehensive physical and psychological evaluation;
2. physical/occupational therapies;
3. a multidisciplinary treatment plan; and,
4. a method to report clinical outcomes.

Coordinated Plan Deductible

The amount you must pay toward the allowed amount for certain covered services each benefit year before Blue Cross begins to pay benefits. Deductibles are shown in the Benefit Chart.

Cosmetic Surgery

Surgery and other cosmetic health services which are chiefly intended to improve appearance and are not medically necessary as determined by Blue Cross.

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 drug is purchased.

Custodial Care

Services that we determine are for the primary purpose of meeting personal needs. These services can be provided by persons without professional skills or training. Custodial care does not include skilled care. Custodial care includes giving medicine that can usually be taken without help, preparing special foods, helping you to walk, get in and out of bed, dress, eat, bathe, and use the toilet.

Deductible

The amount you must pay toward the allowed amount for certain covered services each year before we begin to pay benefits. The deductible is the same as the Coordinated Plan deductible. The deductibles for each person and family are shown on the Benefit Chart. The dollar amount reimbursed or paid by a Coupon will not count toward your deductible.

Your coinsurance and deductible amount will be based on the negotiated payment amount Blue Cross 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 and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements Blue Cross may receive from other parties.

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 online evaluation and management health care service provided by a physician or other qualified health care Provider using the Internet or similar secure communications network to communicate with an established patient.

Facility

A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, a home health agency, or freestanding birthing center when services are billed on a facility claim.

Foot Orthoses

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

Freestanding Ambulatory Surgical Center

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

Group Contractholder	The employer to which the group contract is issued.
Group Member	The member for whom coverage has been provided by the group contractholder or association.
Habilitative Services	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.
Health Care Professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, occupational and speech therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
Hearing Aid	A monaural hearing aid, set of binaural hearing aids, or other device worn by the recipient to improve access to and use of auditory information.
Hearing Aid Accessory	Chest harness, tone and ear hooks, carrying cases, and other accessories necessary to use the hearing aid, but not included in the cost of the hearing aid.
Home Health Agency	A Medicare-approved facility that sends health professionals and home health aides into a person’s home to provide health services.
Hospice Care	A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals suffering from a terminal disease or condition.

Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Illness	A sickness, injury, pregnancy, mental illness, chemical dependency, or condition involving a physical disorder.
Investigative	The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by Blue Cross to be medically effective for the condition being treated. Blue Cross will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health plans must evaluate these technologies. Blue Cross believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.
Lifetime Maximum	The cumulative maximum payable for covered services incurred by you during your lifetime under this Plan. The lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copays, penalties and other amounts. Refer to the Benefit Chart 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, unless they are medically necessary and part of specialized therapy for the member's condition.
Medical Emergency	Medically necessary care which a reasonable lay person 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. Emergency medical condition is a sudden onset of symptoms of sufficient severity, including

	severe pain, such that a reasonable layperson could reasonably expect the absence of immediate medical attention to result in a condition described as a medical emergency.
Medically Necessary and Appropriate (Medical Necessity and Appropriateness)	With respect to services other than mental health care services: Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (c) not primarily for the convenience of the member, physician, or other health care provider, and not more costly that an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. Blue Cross reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a Service, Supply or covered medication is Medically Necessary and Appropriate. No benefits will be provided unless Blue Cross determines that the Service, Supply or covered medication is Medically Necessary and Appropriate. With respect to mental health care Services: Services appropriate, in terms of type, frequency, level, setting, and duration, to the member's diagnosis or condition, and diagnostic testing and preventive Services. Medically Necessary and Appropriate care must be consistent with generally accepted practice parameters as determined by health care Providers in the same or similar general specialty as typically manages the condition, procedure, or Treatment at issue and must: (1) help restore or maintain the member's health; or (2) prevent deterioration of the member's condition.
Medicare	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care 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 Health Care Professional	A psychiatrist, psychologist, independent social worker, licensed professional counselor, marriage and family therapist, or clinical nurse specialist licensed for independent practice that provides treatment for mental disorders.
Mental Illness	A mental disorder as defined in the *International Classification of*

	Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM). Mental disorder does not include alcohol or drug dependence, nondependent abuse of drugs, or mental retardation.
Nonparticipating Provider	A provider that has not entered into a network contract with us or the local Blue Cross and/or Blue Shield Plan.
Otolaryngologist	A physician specializing in diseases of the ear and larynx who is certified by the American Board of Otolaryngology or eligible for board certification.
Out-of-Pocket Maximum	The most each person must pay each calendar year toward the allowed amount for certain covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for certain covered services for that person for the rest of the calendar year. The "Benefit Chart" lists the out-of-pocket maximum amounts. The dollar amount reimbursed or paid by a Coupon will not count toward your out-of-pocket maximum.
Outpatient Behavioral Health Treatment Facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, chemical dependency, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient Care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative Care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Participating Provider	A provider who has entered into a network contract with us or the local Blue Cross and/or Blue Shield Plan.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of Service	Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers. Providers use different types of claim forms to bill for services based on the "place of service." Generally, the place of service is either a clinic or facility. 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 that diagnostic imaging delivered in an outpatient setting.
Plan	The Plan of benefits established by the plan administrator.
Prescription Drugs	Drugs that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
Provider	A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered to provide the health services billed by that provider and a health care facility licensed under law in the state in which it is located tp provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also includes home health agencies.
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.
Residential Behavioral Health Treatment Facility	A facility licensed under state law in the state in which it is located that provides inpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, chemical dependency or drug addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Residential Hospice	Residential hospice care is provided when care is needed 24 hours a day. It is offered in a freestanding facility that has a home-like setting. Residential hospice is a good option when: family and friends are not able to provide care at home but want their loved one to be in a home-like setting.
Respite Care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
Retail Health	A clinic, also referred to as a convenience clinic, located in a retail

Clinic	establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Services	Health care services, procedures, treatments, durable medical equipment, medical supplies, articles and prescription drugs.
Skilled Care	Services rendered other than in a Skilled Nursing Facility that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the Plan.
Skilled Nursing Care – Extended Hours	Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's heath status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.
Skilled Nursing Care – Intermittent Hours	Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.
Skilled Nursing Facility	A Medicare-approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.
Social Security Disability	Total disability as determined by Social Security.
Supervised Employees	Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health

professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supply

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

Supplies do not include such things as:
1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; or,
6. informational materials.

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.

Telemonitoring Services

The remote monitoring of clinical data related to the member's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a provider for analysis. Telemonitoring is intended to collect an member's health-related data for the purpose of assisting a provider in assessing and monitoring the member's medical condition or status.

Terminally Ill Patient

An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.

Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.