

Blue Cross and Blue Shield of Minnesota
Employee Group
Coupe Health Plan

Effective January 1, 2023

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INSERT

Blue Cross Blue Shield of Minnesota Employee Group Coupe Plan

98731/001

Effective Date of Change January 1, 2023

Attention: This insert amends the Group Healthcare Summary Plan Description for the employees of **Blue Cross Blue Shield of Minnesota Employee Group Coupe Plan**
Effective **January 1, 2023**

(Print date on back cover **03/2023**)

Effective **January 1, 2023**, the following revisions are applicable:

1) The following information is applicable to the beginning of the Coordination of Benefits (COB) section immediately prior to the Order of Benefit Determination subsection:

Notice

1. When the Coupe plan is primary, the member is responsible for filing a manual claim with Explanation of Benefits (EOB) to the secondary insurance carrier in order to have those claims processed as deemed appropriate by the secondary insurance carrier.
2. When the Coupe plan is secondary, the member's provider of services or member must submit the EOB from the primary insurance carrier to Coupe for the claim to be processed and considered for payment.

2) The following information is applicable to the Prescription Drug Card Program section table and second paragraph:

*90 day is 3x the Tier at participating 90-day retail pharmacies only

**Mail order is 2x Tier 1

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of a 31-90 day supply is allowed at participating 90-day retail pharmacies only with a copay per 30-day supply. To utilize a 90-day participating retail pharmacy, verify that your pharmacy participates in the 90-day network and present your prescription for a 90-day fill of the eligible prescription medication.

OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our Customer Service Department at 1-833-749-1969. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor pongase en contacto con nuestro Departamento de Servicio al Cliente al 1-833-749-1969. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose of the Plan

The plan is intended to help you and your covered dependents pay for the costs of medical care. The plan does not pay for all of your medical care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay deductibles, copayments, and coinsurance.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity in mental health and substance use disorder treatment. Generally, this law provides that:

- a. Mental health and substance use disorder services are to be covered on the same basis as similar medical services;
- b. Cost-sharing for mental health and substance use disorder services can be no more restrictive than cost sharing for similar medical services; and
- c. Treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

Using coupehealth.com to Get More Information

Once enrolled, you can register for and log into the Coupe Health member portal at coupehealth.com. The Coupe Health member portal is your online hub for everything you need as a Coupe Health member:

- Find a doctor, pharmacy, and your cost depending on where you go.
- View your monthly statements and claims and make payments.
- Get in touch with your Coupe Health Pro.
- View your digital ID card.
- Access health and wellness tools and programs at no cost to you.

Coupe Health Pro

Your Coupe Health Pro is a concierge resource that can help you navigate your health with confidence. Your Health Pro can assist with a variety of different situations as noted below:

- Assist in finding a high quality provider.
- Help set-up appointments before your first visit.
- Answer any of your questions on all things Coupe Health such as billing questions, doctor questions, or even general insurance questions.

To get in touch with your Health Pro, contact the Customer Service number on the back of your ID card.

The concierge Health Pro experience is different than a traditional customer service experience. You will have the opportunity to work with a dedicated Health Pro to resolve your healthcare needs or questions until resolved. Since the Health Pro provides a more customized experience, a Health Pro will generally take your request, research the best possible solution for you, and present that solution back to you within one business day.

Definitions

Near the end of this booklet you will find a section called [Definitions](#), which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Medical Care

Even if the plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening, but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Having a primary care physician is a good decision:

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting coupehealth.com (log in and go to Benefits> Find a Doctor and Compare Costs).

Beginning of Coverage

The section of this booklet called [Eligibility](#) will tell you what is required for you to be covered under the plan and when your coverage begins.

Limitations and Exclusions

In order to maintain the cost of the plan at an overall level that is reasonable to all plan members, the plan contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions to determine if the plan will meet your healthcare needs.

Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish these standards at coupehealth.com (log in and go to Benefits> Employer Benefits> Library> Documents). The definition of medical necessity is found in the [Definitions](#) section of this booklet.

In some cases, the plan requires that you or your treating physician precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid

all monies necessary for coverage to be in force on the date that services or supplies are rendered. The section called [Medical Necessity and Precertification](#) later in this booklet tells you when precertification is required and how to obtain precertification.

In-Network Benefits

One way in which the plan tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

In-network providers are hospitals, physicians (primary and specialty), pharmacies, and other healthcare providers or suppliers that contract with us or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price.

Examples of the plan's in-network providers are:

- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Laboratories
- Bariatric Surgery Network
- Select Lab Network
- Behavioral Health Network
- Substance Use Disorder Providers
- Expanded Psychiatric Services
- Participating Chiropractors
- Participating Physician Assistants
- Participating Nurse Practitioners
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Participating CRNA
- Participating Ground Ambulance
- Participating Licensed Registered Dietitian Network
- Preferred DME Supplier
- Participating Air Medical Transport

- Preferred Home Health Network
- Preferred Home Infusion Network

To locate in-network providers, go to coupehealth.com (log in and go to Benefits> Find a Doctor and Compare Costs, then follow the prompts and instructions to search for your doctor).

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit coupehealth.com. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Minnesota or the local Blue Cross and/or Blue Shield plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as [Other Covered Services](#).

If a network provider is terminated **without** cause from our network while you are a continuing care patient, you may request to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates under the plan. After the provider's contract is terminated, the provider cannot bill you for amounts in excess of the in-network allowed amounts under the plan. For this purpose of requesting this continuity of care, a continuing care patient is defined as an individual who:

- Is or was determined to be terminally ill and is receiving treatment for such illness;
- Is undergoing a course of treatment for a serious and complex condition;
- Is pregnant and undergoing a course of treatment for the pregnancy;
- Is undergoing a course of institutional or inpatient care; or
- Is scheduled to undergo non-elective surgery, including receipt of post-operative care, with respect to such a surgery.

If you have successfully transitioned to another in-network provider, if you have met or exceeded benefit limitations of the plan, or if care is not medically necessary, you will no longer be eligible for this continuity of care. If we deny your request for continuity of care, you may file an appeal following the procedures described in the Claims and Appeals section of this booklet.

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.

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

When you see a doctor or other health care provider, you may owe certain out-of-pockets 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 visits a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-Network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for the 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 visits 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. If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact the No Surprise Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or complaint. Or, you can submit a complaint online at <https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.cms>.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Minnesota. Blue Cross is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross not created under the original agreement.

Claims and Appeals

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. Thereafter, you may have the right to an external review by an independent, external reviewer. The provisions of the plan dealing with claims, appeals, and external reviews are found further on in this booklet.

Changes in the Plan

From time to time it may be necessary to change the terms of the plan. The rules we follow for changing the terms of the plan are described later in the section called [Changes in the Plan](#).

Termination of Coverage

The section below called [Eligibility](#) tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

WHO IS ELIGIBLE

Note: If you, your spouse/domestic partner, and/or dependent are Associates of the Employer, you may be covered as either an Associate or as a Dependent, but not as both. Your eligible Dependent children may be covered under either parent's coverage, but not both.

Eligible Associates

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

You must sign and return the Coupe Health participant agreement and credit agreement, if applicable to your plan. If you fail to sign and return the participation agreement but otherwise enroll in coverage, you will be deemed by the plan as having accepted the terms and conditions of coverage, including the terms outlined in the participant agreement, and your enrollment will be considered an acknowledgement that you agree to comply with the plan's terms, including the terms outlined in the participant agreement. Notwithstanding anything to the contrary, the plan reserves the right to decline a member's enrollment for failure to sign and return the participant agreement.

Spouse/Domestic Partner

Spouse/domestic partner, meaning:

- a. Legally married spouse;
- b. Legally separated spouse;
- c. Qualified domestic partner (opposite, same or different) of an eligible associate, if all of the following criteria are met:
 1. Is not related to the other partner by blood or adoption;
 2. Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
 3. Is the sole domestic partner of the partner and has been a member of this domestic partnership for the last 12 months;
 4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner and meets (or agrees to meet) the requirements of any applicable federal state, or local laws or ordinances for domestic partnerships which are currently enacted, or which may be enacted in the future

Dependent Children

1. Natural-born dependent children to age 26.
2. Children of the domestic partner of the associate provided domestic partner remains covered.
3. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
4. Stepchildren to age 26 provided the stepchild parent remains covered as a spouse/domestic partner.
5. Dependent children for whom you or your spouse/domestic partner have been appointed legal guardian to age 26. After initial proof, the Claims Administrator may request proof annually.
6. Foster children placed with you or your spouse/domestic partner by an authorized placement agency or by judgement decree, or other order of any court of competent jurisdiction. After initial proof, the Claims Administrator may request proof annually.
7. Grandchildren to age 26 provided:
 - a. They are members of the associate's household;
 - b. Are claimed as exemptions on the associate's or spouse/domestic partner's Federal income tax return; and

- c. For whom you or your spouse/domestic partner have legal custody or have been appointed legal guardian:

Grandchildren who were eligible prior to age 19 may remain on the Plan to age 26 without needing to be claims as an exemption on the associate's or spouse/domestic partner's Federal income tax return. After initial proof, the Claims Administrator may request proof annually.

8. Children of the associate who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependent can obtain, without charge, a copy of such procedures from the Plan Administrator.

Disabled Dependent Children

Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply;

- a. Chiefly dependent upon associate for support and maintenance; and
- b. Incapable of self-sustaining employment because of developmental disability, mental illness or disorder or physical disability; and
- c. For whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and
- d. Must have become disabled prior to reaching limiting age.

Adding New Associates

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

1. If the plan administrator receives your application within 30 days after you become eligible, coverage for you and your eligible dependents starts the first day employed.

Adding New Dependents

Adding a Spouse/Domestic Partner and/or stepchildren

1. If the plan administrator receives the application within 60 days of the date of marriage, coverage for your spouse/domestic partner and/or stepchildren starts on the date of marriage.

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

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

Adding Disabled Dependents

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

1. If the plan administrator receives the application within 60 days of the date of eligibility, coverage for your disabled dependent starts on the date of eligibility.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. In order to enroll the eligible employee or dependent **must notify the claims administrator within 60 days** of the triggering event, unless otherwise noted below. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 60 days after the

birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Event
<p>Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission):</p> <ul style="list-style-type: none"> • Loss of eligibility for employer-sponsored coverage • Plan no longer offers benefits • Termination of all employer contributions • Termination of employment or reduction in hours • Legal separation or divorce or domestic partnership ends • Loss of dependent child status • Death of associate • Employer bankruptcy • COBRA exhaustion • Associate becomes entitled to Medicare
<p>Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.</p>
<p>Gaining or becoming a dependent due to marriage or domestic partnership criteria are met.</p>
<p>Gaining a dependent due to birth, adoption, placement for adoption, or placement for foster care.</p>
<p>An individual who loses or gains eligibility for medical assistance (Medicaid) or Children's Health Insurance Program (CHIP) must notify the claims administrator within 60 days.</p>
<p>Child support order or other court order to provide coverage.</p>

Changes in Membership Status

For the health care plan to administer consistent coverage for you and your dependents, you must keep your associate Benefit Department informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, domestic partnership criteria are met or are no longer met, etc.) that may affect your coverage.

Leave of Absence or Layoff

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

Termination of Your Coverage

Coverage ends on the earliest of the following dates:

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

- d. You request that coverage be terminated.
 - e. You retire.
- 3 For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month the employee and spouse divorce or legally separate or terminate their civil union, or the domestic partner no longer meets the domestic partner requirements.
 - 4 For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month:
 - a. A covered stepchild is no longer eligible because the employee and spouse divorce or legally separate.
 - b. A covered dependent is no longer eligible because the employee and the domestic partner terminate their domestic partnership.
 - c. A covered dependent is no longer eligible because the employee and civil union spouse terminate their civil union.
 - d. The dependent child reaches the dependent-child age limit.
 - e. The disabled dependent is no longer eligible.

Extension of Benefits

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

Continuation of Coverage

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

Qualifying Events

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

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

Special Second Election Period

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

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustments assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get advanced payment of 65 percent of premiums paid for qualified health insurance, including

continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct	Employee and dependents	<ul style="list-style-type: none"> • 18 months from the first of the month following the event, or • Enrollment date in other group coverage
Reduction in hours	Due to lay-off, leave of absence strike, lockout, change from full-time to part-time employment	Employee and dependents	<ul style="list-style-type: none"> • 18 months from the first of the month following the event, or • Enrollment date in other group coverage
Death of employee		Dependents	<ul style="list-style-type: none"> • 36 months from the date of the employee's death, • Enrollment date in other group coverage, or • Date coverage would otherwise end if the employee had lived.
Employee becomes enrolled in Medicare		Dependents	<ul style="list-style-type: none"> • 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end
Divorce or legal separation	<ul style="list-style-type: none"> • Spouse/ex-spouse who was covered on the day before the entry of the valid decree of dissolution of marriage. • If coverage for spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event 	Spouse/ex-spouse and any dependent children who lose coverage	<ul style="list-style-type: none"> • 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is the earlier or earliest of
Dependent child is no longer eligible		Dependent child	<ul style="list-style-type: none"> • 36 months from the date of the event, or • Enrollment date in other group coverage, or • Date coverage would otherwise end
Employer filing Chapter 11 bankruptcy	<ul style="list-style-type: none"> • You are a retiree of the employer filing Chapter 11 bankruptcy • Includes substantial reduction in hours within one (1) year of filing 	Retiree	Lifetime continuation
		Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death
		Surviving spouse	<ul style="list-style-type: none"> • Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death • Lifetime continuation when retiree is deceased at time of event and spouse is already covered by the plan

Qualifying Event Extensions

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

Total Disability of Dependents

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

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

Second Qualifying Event

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

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

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

Employee Enrolled In Medicare

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Employee and dependents may extend coverage for a maximum period of 24 months.

Continuation Notice Obligations

You or your dependents each are entitled to an independent right to elect continuation coverage. Therefore, a spouse/ex-spouse may not decline coverage for the other spouse/ex-spouse and a parent cannot decline coverage for a non-minor dependent child who is eligible to continue coverage.

In addition, a dependent may elect continuation coverage even if the covered employee does not elect continuation coverage.

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

Contact the employer to determine how to elect continuation coverage.

Notices for	Employee/Dependent	Employer	Eligible Employee/Dependent
Coverage termination due to: <ul style="list-style-type: none"> • Termination of employment • Reduction in hours • Death of the employee • Employee becomes enrolled in Medicare 	Notice must be provided to employer within 60 days of the event if the employer is not aware of the event.	Send the qualifying event notice to eligible individuals within 14 days of the event or upon receipt of notice to advise: <ul style="list-style-type: none"> • Of the right to elect continuation coverage or • When continuations is not available and why 	Elect continuation coverage within 60 days of: <ul style="list-style-type: none"> • The qualifying event or • The date of the qualifying event notice, whichever is later

Notices for	Employee/Dependent	Employer	Eligible Employee/Dependent
Coverage termination due to: <ul style="list-style-type: none"> • Divorce or legal separation • Dependent child is no longer eligible 	<ul style="list-style-type: none"> • Notice must be provided to employer within 60 days of the event. • Notice must be provided to employer within 60 days after a later divorce or legal separation when coverage was earlier terminated in anticipation of the divorce or legal separation. 	Upon receipt of notice, notify the eligible individuals: <ul style="list-style-type: none"> • Of the right to elect continuation coverage or • When continuation is not available and why 	Elect continuation within 60 days of: <ul style="list-style-type: none"> • The qualifying event or • The date of the qualifying event notice, whichever is later.
Extension of continuation due to: <ul style="list-style-type: none"> • Disability determination or • New qualifying event 	Notice must be provided: <ul style="list-style-type: none"> • To employer within 60 days of the disability determination or new event add • Before the end of the initial 18-month or 29-month continuation period 	Upon receipt of notice: <ul style="list-style-type: none"> • Notify the eligible individuals of the right to elect continuation coverage, or • Notify you when an extension is not available and why 	Elect continuation within 60 days of: <ul style="list-style-type: none"> • The qualifying event or • The date of the qualifying event notice, whichever is later

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

- The employer no longer provides group dental coverage to any of its employees
- The premium for continuation coverage is not paid when due
- If during an 18-month or 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the employer within 30 days of the final determination
- After electing continuation, you or your dependents become covered under another group dental plan that has an exclusion or limitation with respect to any preexisting condition that you have. Your continuation coverage will terminate after any applicable exclusion or limitation no longer applies.
- After electing continuation coverage, you or your dependent becomes entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered employees or their dependents whether or not they are on continuation coverage.
- Voluntary cancelling your continuation coverage.

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

Continuation Premiums

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

In the event of a dependent’s disability, the premiums for continuation for the employee and dependents can be up to 150 percent of the group rate for months 19-29 if the disabled dependent is covered.

All premiums are paid directly to the employer.

COST SHARING

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Calendar Year Deductible	No Deductible	No Deductible
Calendar Year Out-of-Pocket Maximum	\$2,000 Individual \$4,000 Family	No Out-of-Pocket Maximum

The calendar year out-of-pocket maximum applies on a per member per calendar year basis, subject to the family calendar year out-of-pocket maximum amount. Once a member meets their individual calendar year out-of-pocket maximum, affected benefits for that member will pay at 100% of the allowed amount for the remainder of the calendar year.

The In-Network and Out-of-Network calendar year out-of-pocket maximums apply independently of each other. This means that applicable In-Network cost-sharing amounts apply only towards the In-Network calendar year out-of-pocket maximum. Likewise, applicable Out-of-Network cost-sharing amounts apply only towards the Out-of-Network calendar year out-of-pocket maximum. Thus, if you are receiving care, services, or supplies during the course of a calendar year from both In-Network and Out-of-Network Providers, you may need to satisfy both the In-Network and Out-of-Network calendar year out-of-pocket maximums before all covered benefit percentages under the plan increase to 100%. In certain circumstances as and when required by Federal law, the cost-sharing amounts (copayments) that you are required to pay for out-of-network services will apply to the in-network calendar year out-of-pocket maximum. Those services include:

- Medical or Accident emergency
- Air Ambulance
- Certain non-emergency services performed by out-of-network providers at certain in-network facilities

Other Cost Sharing Provisions

The plan may impose other types of cost sharing requirements such as the following:

- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Amounts in excess of the allowed amount:** As a general rule, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. As one example, certain out-of-network facility claims may include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. This means you could be responsible for these charges if you use an out-of-network provider.
- **Specialty Drug Financial Assistance:** Only the amount you pay out-of-pocket for your specialty drugs will apply to your cost-sharing responsibilities or out-of-pocket limit. The dollar amount of any financial assistance provided to you by providers or manufacturers will not count towards copay or deductible cost-sharing responsibilities or out-of-pocket limit.

Out-of-Area Services

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

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

A. BlueCard® Program

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

When you receive covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

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

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

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, we may process your claims for covered healthcare services through Negotiated Arrangements for National Accounts. The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Special Cases: Value Based Programs

BlueCard Program

We have included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this agreement.

Negotiated Arrangements

If we have entered into a Negotiated Arrangement with Host Blue to provide Value-Based Programs to your members, we will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

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

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

E. Nonparticipating Providers Outside Our Service Area

1. Member Liability Calculation

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

2. Exceptions

In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core service when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is not served by a Host Blue.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. You must contact us to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at <http://www.bcbsglobalcore.com>. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

MEDICAL NECESSITY AND PRECERTIFICATION

The plan will only pay for care that is medically necessary and not investigational, as determined by us. The definitions of medical necessity and investigational are found in the [Definitions](#) section of this booklet.

In some cases described below, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

Inpatient Hospital Benefits

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-833-749-1967 (toll-free).

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for

covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

Outpatient Hospital Benefits, Physician Benefits, Other Covered Services

Precertification is required for certain outpatient hospital benefits, physician benefits, and other covered services excluding Tier 1. You can find more information about the specific services that require precertification at coupehealth.com. This list will be updated no more than twice per calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services, and other covered services. Contact customer service at the telephone number listed on the back of your ID card to be directed to the appropriate number to call for precertification.

The general categories of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the printing of this booklet include:

- Intensive outpatient services and partial hospitalization
- Home health and hospice
- Certain genetic laboratory testing

If precertification is not obtained for the categories listed above, no benefits will be payable under the plan for the services.

- Certain select procedures
- Certain reconstructive procedures
- Certain durable medical equipment

If precertification is not obtained for the categories listed above, no benefits will be payable under the plan for the services.

Provider-Administered Drugs

Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at MN.ExploreMyPlan.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly. Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outstanding basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drugs

HEALTH BENEFITS

Attention: If you receive out-of-network physician benefits (such as out-of-network laboratory services) for a medical emergency or accidental injury in the emergency room of a hospital, those services will also be paid at the applicable in-network coinsurance amounts for such benefits described in the matrices below, and subject to the in-network calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the requirements of the applicable Federal law.

Attention: If you receive non-emergency services provided by an out-of-network provider at certain participating facilities, those services will be paid at the applicable in-network coinsurance and/or copayment amounts for such benefits described in the matrices below, and subject to the in-network calendar year deductible, provided the out-of-network provider has not satisfied the applicable notice and consent requirements. The allowed amount for such non-emergency services performed by an out-of-network provider at certain participating facilities will be determined in accordance with the requirements of the applicable Federal law.

Inpatient Hospital Benefits

Attention: Precertification is required for all hospital admissions except for medical emergency services, maternity admissions, and as required by Federal law. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

Note: There are no deductibles or coinsurance amounts on a Coupe Health plan. Cost-sharing amounts (copays) are required to be paid by the employee member. Copays will never exceed the total allowable cost for a healthcare service. Copay ranges are outlined in the table below. See provider and service-specific copay ranges at www.coupehealth.com or contact a Health Pro at healthpro@coupehealth.com for more information.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Inpatient stay (includes Mental health and substance use disorders) First 365 days of care during each confinement (combined in-network and out-of-network)	Tier 1: 100% of the allowed amount after a \$1,035 copayment Tier 2: 100% of the allowed amount after a \$1,380 copayment Tier 3: 100% of the allowed amount after a \$2,000 copayment	Not covered
Days of confinement in a general hospital, psychiatric specialty hospital, or residential treatment facility extending beyond the 365-day benefit maximum	Tier 1: 100% of the allowed amount after a \$1,035 copayment Tier 2: 100% of the allowed amount after a \$1,380 copayment Tier 3: 100% of the allowed amount after a \$2,000 copayment	Not covered

Attention: If you receive inpatient hospital services in an out-of-network hospital in the Minnesota service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

Inpatient hospital benefits consist of the following if provided during a hospital stay:

- Bed and board and general nursing care in a semiprivate room;
- Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
- Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
- Administration of anesthetics by hospital employees and all necessary equipment and supplies;
- Casts, splints, surgical dressings, treatment and dressing trays;
- Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;
- Physical therapy, hydrotherapy, radiation therapy, and chemotherapy;
- Oxygen and equipment to administer it;
- All drugs and medicines used by you if administered in the hospital;
- Regular nursery care and diaper service for a newborn baby while its mother has coverage;
- Blood transfusions administered by a hospital employee.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward any applicable maximum number of inpatient days.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an inpatient hospital admission as outpatient services. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Outpatient Hospital Benefits

Attention: Precertification is required for certain outpatient hospital benefits. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

Note: There are no deductibles or coinsurance amounts on a Coupe Health plan. Cost-sharing amounts (copays) are required to be paid by the employee member. Copays will never exceed the total allowable cost for a healthcare service. Copay ranges are outlined in the table below. See provider and service-specific copay ranges at www.coupehealth.com or contact a Health Pro at healthpro@coupehealth.com for more information.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>Outpatient facility services (includes mental health and substance use disorders and ambulatory surgical centers)</p>	<p>Tier 1: 100% of the allowed amount after a \$550 copayment Tier 2: 100% of the allowed amount after a \$740 copayment Tier 3: 100% of the allowed amount after a \$1,235 copayment</p>	<p>Not covered</p>
<p>Emergency services/emergency room – medical emergency and accidental care Note: In some circumstances where you were not able to choose the provider who rendered care, you are not responsible for any amount above what you would have been required to pay (such as copays) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. Please refer to 'Special Circumstances'. If the care you receive is due to a medical emergency, prior authorization is not required.</p>	<p>Tier 1: 100% of the allowed amount after a \$325 copayment Tier 2: 100% of the allowed amount after a \$325 copayment Tier 3: 100% of the allowed amount after a \$325 copayment</p>	<p>100% of the allowed amount after a \$325 copayment</p>
<p>Outpatient weight control/bariatric surgery</p>	<p>Tier 1: 100% of the allowed amount after a \$550 copayment Tier 2: 100% of the allowed amount after a \$740 copayment Tier 3: 100% of the allowed amount after a \$1,235 copayment</p>	<p>Not covered</p>
<p>Outpatient basic diagnostic lab and pathology</p>	<p>Tier 1: 100% of the allowed amount after a \$10 copayment Tier 2: 100% of the allowed amount after a \$15 copayment Tier 3: 100% of the allowed amount after a \$25 copayment</p>	<p>Not covered</p>
<p>Outpatient advanced diagnostic lab and pathology</p>	<p>Tier 1: 100% of the allowed amount after a \$50 copayment Tier 2: 100% of the allowed amount after a \$65 copayment Tier 3: 100% of the allowed amount after a \$110 copayment</p>	<p>Not covered</p>
<p>Outpatient x-ray</p>	<p>Tier 1: 100% of the allowed amount after a \$50 copayment Tier 2: 100% of the allowed amount after a \$65 copayment Tier 3: 100% of the allowed amount after a \$110 copayment</p>	<p>Not covered</p>
<p>Outpatient advanced imaging</p>	<p>Tier 1: 100% of the allowed amount after a \$170 copayment Tier 2: 100% of the allowed amount after a \$230 copayment Tier 3: 100% of the allowed amount after a \$380 copayment</p>	<p>Not covered</p>

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Urgent care	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered

Physician Benefits

Attention: Precertification is required for certain physician benefits. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

The benefits listed below apply only to the physician’s charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient facility copayments. Examples may include 1) laboratory testing performed in the physician’s office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

Note: There are no deductibles or coinsurance amounts on a Coupe Health plan. Cost-sharing amounts (copays) are required to be paid by the employee member. Copays will never exceed the total allowable cost for a healthcare service. Copay ranges are outlined in the table below. See provider and service-specific copay ranges at www.coupehealth.com or contact a Health Pro at healthpro@coupehealth.com for more information.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Physician services – primary care (includes mental health and substance use disorders)	Tier 1: 100% of the allowed amount after a \$15 copayment Tier 2: 100% of the allowed amount after a \$25 copayment Tier 3: 100% of the allowed amount after a \$40 copayment	Not covered
Physician services – specialist (includes mental health and substance use disorders)	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered
Retail health clinic	Tier 1: 100% of the allowed amount after a \$15 copayment Tier 2: 100% of the allowed amount after a \$25 copayment Tier 3: 100% of the allowed amount after a \$40 copayment	Not covered
Urgent care	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
E-visits/telehealth services	Tier 1: 100% of the allowed amount after a \$15 copayment Tier 2: 100% of the allowed amount after a \$25 copayment Tier 3: 100% of the allowed amount after a \$40 copayment	Not covered
Doctors on Demand	Tier 1: 100% of the allowed amount, no copayment Tier 2: 100% of the allowed amount, no copayment Tier 3: 100% of the allowed amount, no copayment	Not covered
Prenatal maternity care	Tier 1: 100% of the allowed amount, no copayment Tier 2: 100% of the allowed amount, no copayment Tier 3: 100% of the allowed amount, no copayment	Not covered
Maternity delivery	Tier 1: 100% of the allowed amount after a \$1,035 copayment Tier 2: 100% of the allowed amount after a \$1,380 copayment Tier 3: 100% of the allowed amount after a \$2,000 copayment	Not covered
Allergy testing and treatment	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid with the applicable in-network coinsurance and/or copayment amounts for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.

Physician Preventive Benefits

Attention: In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, the applicable office visit or outpatient facility cost sharing amounts under your physician benefits or outpatient hospital benefits may apply. In any case, applicable office visit or facility visit cost sharing amounts may still apply when the primary purpose for your visit is not routine preventive services and/or routine immunizations.

Under the Affordable Care Act, non-grandfathered plans are required to provide in-network coverage for all of the following without cost-sharing:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee to Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidenced-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and,
- With respect to women, preventive care and screenings as provided in the binding, comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, including (but not limited to) all Food and Drug Administration (FDA)-approved contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (including dependent daughters) with reproductive capacity.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine preventive services and immunizations: (See MN.ExploreMyPlan.com/preventiveservices for a listing of specific preventive services and immunizations)	Tier 1: 100% of the allowed amount, no copayment Tier 2: 100% of the allowed amount, no copayment Tier 3: 100% of the allowed amount, no copayment	Not covered
Routine eye exam	Tier 1: 100% of the allowed amount, no copayment Tier 2: 100% of the allowed amount, no copayment Tier 3: 100% of the allowed amount, no copayment	Not covered

Other Covered Services

Attention: Precertification is required for certain other covered services. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

Note: There are no deductibles or coinsurance amounts on a Coupe Health plan. Cost-sharing amounts (copays) are required to be paid by the employee member. Copays will never exceed the total allowable cost for a healthcare service. Copay ranges are outlined in the table below. See provider and service-specific copay ranges at www.coupehealth.com or contact a Health Pro at healthpro@coupehealth.com for more information.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Acupuncture Limited to a combined maximum of 20 visits per member per benefit period	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered
Ambulance services (includes ground and air)	Tier 1: 100% of the allowed amount after a \$325 copayment Tier 2: 100% of the allowed amount after a \$325 copayment Tier 3: 100% of the allowed amount after a \$325 copayment	100% of the allowed amount after a \$325 copayment
Assisted reproductive technology (ART) services Lifetime maximum for medical services and prescription drugs combined for ART services: \$25,000 per person Included in this lifetime maximum limit is coverage for the retrieval, banking, cryopreservation, preservation, storage, and thawing of a member's embryo, sperm, or ova (eggs), as well as the banking, cryopreservation, preservation, storage, and thawing of a donor's embryo, sperm, or ova. Cryopreservation of embryo, sperm, and ova is covered for any diagnosis.	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered
Chiropractic services	Tier 1: 100% of the allowed amount after a \$35 copayment Tier 2: 100% of the allowed amount after a \$45 copayment Tier 3: 100% of the allowed amount after a \$75 copayment	Not covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints</p> <p>Note: For DME the allowed amount will generally be the smaller of the rental or purchase price</p>	<p>Tier 1: 100% of the allowed amount after a \$75 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$100 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$170 copayment</p>	Not covered
<p>Hearing aids</p> <p>Limited to 1 hearing aid per ear every 3 plan years for ages 18 and under due to hearing loss related to congenital malformation</p>	<p>Tier 1: 100% of the allowed amount after a \$75 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$100 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$170 copayment</p>	Not covered
<p>Home health care</p> <p>Home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician</p>	<p>Tier 1: 100% of the allowed amount after a \$35 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$45 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$75 copayment</p>	Not covered
<p>Home infusion benefits</p> <p>Home infusion benefits include coverage of certain provider-administered drugs ordered by your attending physician and administered by a home infusion service provider in the home or in an infusion site associated with the home infusion service provider.</p> <p>In –network benefits include coverage of the provider-administered drug and drug infusion related administration services.</p> <p>See Provider-Administered Drugs paragraph under the Medical Necessity and Precertification section of this booklet for precertification requirements of these drugs.</p>	<p>Tier 1: 100% of the allowed amount after a \$35 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$45 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$75 copayment</p>	Not covered
<p>Hospice service and respite care</p> <p>Hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live</p>	<p>Tier 1: 100% of the allowed amount after a \$185 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$245 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$419 copayment</p>	Not covered
<p>Rehabilitative and habilitative physical, occupational and speech therapy</p>	<p>Tier 1: 100% of the allowed amount after a \$35 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$45 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$75 copayment</p>	Not covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>Skilled nursing facility</p> <p>Includes facility charges for room, board, and routine nursing care when the patient is recovering from a serious illness or injury, confined to a bed with a long-term illness or injury, or has a terminal condition; the admission must take place within 14 days after the patient leaves the hospital and that hospital stay must have lasted at least three days in a row for the same illness or injury; the patient's doctor must visit him at least once every 30 days and these visits must be written in the patient's medical records; the facility must be an approved skilled nursing facility as defined by the Social Security Act</p> <p>Limited to 120 days per member, per benefit period</p>	<p>Tier 1: 100% of the allowed amount after a \$930 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$1,240 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$2,000 copayment</p>	Not covered
<p>Wigs (cranial prostheses, toupees or hairpieces)</p> <p>Related to cancer treatment or alopecia areata only</p> <p>Limited to one per member, per benefit period</p>	<p>Tier 1: 100% of the allowed amount after a \$930 copayment</p> <p>Tier 2: 100% of the allowed amount after a \$1,240 copayment</p> <p>Tier 3: 100% of the allowed amount after a \$2,000 copayment</p>	Not covered

Travel Benefit

SERVICE	PLAN PAYS
<p>Travel Benefit</p> <ul style="list-style-type: none"> If you live more than 50 miles from a participating treating provider eligible to perform services, there may be a travel benefit available for expenses directly related to covered plan benefits, except those services with a separate benefit –specific travel benefit 	\$5,000 per lifetime aggregate maximum
Travel expenses for transplants to a Blue Distinction Center only	\$5,000

Prescription Drug Card Program

Prescriptions	Coupe Health Ranges			
	Tier 1 Retail	Tier 2 Retail	90d Retail* Tier 1/Tier 2	Mail Order**
Generic	\$5	\$10	\$15/\$30	\$10
Preferred Brand	\$15	\$20	\$45/\$60	\$30
Non-Preferred Brand	\$25	\$30	\$75/\$90	\$50
Specialty – Mail order Only	Mail Only	Mail Only	Mail Only	\$30
*90 day is 3x the Tier				
**Mail order is 2x Tier 1				

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; smoking deterrents; infertility medication; sexual dysfunction/impotence medication; and oral contraceptives and contraceptive patches (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of a 31-90 day supply is allowed at retail with a copay per 30-day supply.

Prescriptions for more than a 30-day supply may be purchased through the mail order program.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Prior Authorization

Certain Prescription Drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting the Prescription Drug Card Program Administrator.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program

Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Step Therapy

What is Step Therapy?

Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug

list) that has been proven effective for most people with your condition before you can move up a “step” to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as

“Step 1” Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Plan Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as “Step 2” Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are generic drugs proven to be safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.
- Back-up drugs - Step 2 and Step 3 drugs - are brand-name drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?

The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug then their Physician can prescribe a back-up (step 2 or step 3) drug. Prior authorization documenting the trial and failure of the front-line drug is required prior to the back-up drug being approved to be filled. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (step 2 drugs) listed by the plan is appropriate.

If on Step Therapy effective date, the Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription”; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Specialty Drug means those Prescription Drugs, medicines, agents, substances and other therapeutic products that include one or more of the following particular characteristics:

- 1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);
- 2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and the limit waste;
- 3) Limited pharmaceutical supply chain distribution as determined by the applicable drug’s manufacturer, and/or
- 4) Relative expense.

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	In-Network Providers	Out-of-Network Providers
Outpatient health care professional services including: <ul style="list-style-type: none"> • Office visit • Counseling 	Covered Benefit *Copay amount is dependent on service type and location received.	Covered Benefit *Copay amount is dependent on service type and location received.
Professional services for gender affirming procedures for the treatment of gender dysphoria	Covered Benefit *Copay amount is dependent on service type and location received.	Covered Benefit *Copay amount is dependent on service type and location received.

Gender Confirmation Care - Notes

1. Services include related preparation and follow-up treatment care.
2. 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.
3. Gender-specific preventive services are covered for transgender persons appropriate to their anatomy. For preventive care services, please refer to 'Preventive Care.'
4. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
5. For prescription drugs for the management of dysphoria, please refer to "Prescription Drugs."
6. For hospital/facility services, please refer to "Hospital Inpatient Care" and Hospital Outpatient Care."
7. 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."
8. For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
9. For more information call your Coupe Health Pro at 1-833-749-1969.

Gender Confirmation Care – Not Covered

Treatment, services, or supplies that are not medically necessary.

Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage and the transporting of the organ and removal team.

Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry
- prediagnostic testing expenses of the actual donor for the approved transplant
- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other

plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Tissue, cell and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the plan when determined to be medically necessary and not investigational. These transplants include but are not limited to: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

Diabetes Services

Diabetic benefits are available at no cost to the members who enroll in the Livongo for Diabetes Program. Through the Livongo for Diabetes Program, the member is provided with a connected blood glucose monitoring system, unlimited test strips and other monitoring supplies, as well as information and personalized support from a certified diabetes educator. Members can enroll in the Livongo for Diabetes Program by visiting Welcome.Livongo.com/Coupe or calling 800-945-4355 and use the registration code "Coupe".

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

Noncompliant Plan: If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

Employee/Dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the group, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent Child – Parents Not Separated or Divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent Child – Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child’s healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - a. first, the plan of the custodial parent;
 - b. second, the plan covering the custodial parent’s spouse;
 - c. third, the plan covering the non-custodial parent; and,
 - d. last, the plan covering the non-custodial parent’s spouse.
2. If a court decree states that a parent is responsible for the dependent child’s healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:

- a. first, the plan of the spouse of the court-ordered parent;
- b. second, the plan of the non-court-ordered parent; and,
- c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child’s healthcare expenses or healthcare coverage, the provisions of “Dependent Child – Parents Not Separated or Divorced” (the “birthday rule”) above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the “birthday rule” shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the “birthday rule” as if those individuals were parents of the child.

Active Employee or Retired or Laid-Off Employee:

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse’s plan, the retiree plan will be primary and the spouse’s active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer’s plan (the “COBRA plan”) and is also covered as a dependent under an active spouse’s plan, the COBRA plan will be primary and the spouse’s active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse’s plan (the “COBRA plan”) and is also covered as a dependent under a new spouse’s plan, the COBRA plan will be primary and the new spouse’s plan will be secondary.

Longer/Shorter Length of Coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal Division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of Amount of Payment

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

COB Terms

Allowable Expense: Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any health care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term “allowable expense” does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term “allowable expense” does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan’s provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term “birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial Parent: The term “custodial parent” means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contract: The term “group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital Indemnity Benefits: The term “hospital indemnity benefits” means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant Plan: The term “noncompliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

Plan: The term “plan” includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary Plan: The term “primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan: The term “secondary plan” means a plan that is not a primary plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We 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 the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare’s coverage, depending upon, among other things, the size of your group, whether your group is

a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

SUBROGATION

Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid plan benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce this plan's rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

HEALTH BENEFIT EXCLUSIONS

In addition to other exclusions set forth in this booklet, we **will not** provide benefits under any portion of this booklet for the following:

A

Anesthesia services or supplies or both by local infiltration.

C

Services or expenses of a hospital stay, except one for an emergency, unless we **certify** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

Services or expenses for which a **claim** is not properly submitted to Blue Cross.

Services or expenses for a **claim we have not received within 12 months** after services were rendered or expenses incurred.

Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.

Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

D

Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and

similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.

Except as may be otherwise expressly covered in this booklet, **dietary** instructions.

E

Services, care, or treatment you receive after the **ending date of your coverage**. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

Eyeglasses or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the section of this booklet called [Other Covered Services](#).

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

F

Services or expenses in any **federal hospital or facility** except as required by federal law.

Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).

G

Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

H

Hearing aids or examinations or fittings for them. This exclusion does not apply to hearing aids for children 18 years and younger due to congenital malformation.

I

Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

L

Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

M

Services or expenses we determine are not **medically necessary**.

Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

N

Services or expenses of any kind for **nicotine addiction** except as provided under the section of the booklet called [Physician Preventive Benefits](#).

Services, care or treatment you receive during any period of time with respect to which we have **not been paid for your coverage** and that **nonpayment** results in termination.

O

Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

P

Hot and cold **packs**, including circulating devices and pumps.

Services or expenses rendered by out-of-network **physician assistants** (P.A.s) (including P.A.s who assist in surgery).

Expenses for outpatient **prescription drugs**.

Private duty nursing unless previously stated as a covered service.

R

Services or expenses for **recreational** or educational therapy (except for plan-approved diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs).

Hospital admissions in whole or in part when the patient primarily receives services to **rehabilitate** such as physical therapy, speech therapy, or occupational therapy unless the admission is determined to be medically necessary for acute inpatient rehabilitation.

Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.

Replacement or upgrade of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.

Room and board for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.

Routine physical examinations except for the services described in [Physician Preventive Benefits](#).

Routine well child care and routine immunizations except for the services described in [Physician Preventive Benefits](#).

S

Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition).

Services or expenses for reverse **sterilization**.

Services, **supplies**, equipment, accessories or other items which can be purchased at retail establishments or otherwise over-the-counter without a doctor's prescription that are not otherwise covered services under another section of this booklet, including but not limited to:

- Hot and cold packs;

- Standard batteries used to power medical or durable medical equipment;
- Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover;
- Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
- Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
- Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.

T

Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or “dead” teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under [Other Covered Services](#).

Dental treatment for or related to Phase II **temporomandibular joint (TMJ) disorders** according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician’s prescription.

Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.

Travel, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

W

Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.

Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **workers’ compensation** or employers’ liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

CLAIMS AND APPEALS

Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to handle without an appeal. The phone number to reach our Customer Service Department is on the back of your ID card.

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling our Customer Service Department. You can also go to coupehealth.com, then log in and go to the Benefits> Employer Benefits> Library> Documents to download and print the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

Post-Service Claims

What Constitutes a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form or go to coupehealth.com, then log in and go to Benefits> Employer Benefits> Library> Documents to download and print the form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 10527, Birmingham, Alabama 35202-0500. Claims must be submitted and received by us within 12 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. If we need additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan.

In order to file a pre-service claim you or your provider must call our Health Management Department at 1-833-749-1969 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing.

Written pre-service claims should be sent to us at Blue Cross and Blue Shield, Birmingham Service Center, Birmingham, Alabama 35202-0500.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing information to us.

Non-Urgent Pre-Service Claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy Pre-Determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

Concurrent Care Determinations

Determinations by Us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and

we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 1-833-749-1969 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-833-749-1969.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

The rules in this section of this booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- Any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Our denial of a pre-service claim;
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or,
- Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by us to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Your Group's Adverse Eligibility and Rescission Determinations: If you wish to file an appeal of your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go

to coupehealth.com then log in and go to Benefits> Employer Benefits> Library> Documents to download and print the form. Once there, you may request a copy of the form.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available). (The best way to satisfy this requirement is to include a copy of your claims report with your appeal.); and,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield
Attention: Customer Service Department – Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 1-833-749-1969 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-833-749-1969.

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

Blue Cross and Blue Shield
Attention: Health Management Department – Appeals
P.O. Box 2504
Birmingham, Alabama 35201-2504

or

- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy:

Blue Cross and Blue Shield
Attention: Health Management Department – Appeals
P.O. Box 362025
Birmingham, Alabama 35236

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct of the Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a healthcare professional who has appropriate expertise. If we

consulted a healthcare professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

Time Limits for Our Consideration of Your Appeal: If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see [Concurrent Care Determinations](#) above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see [Concurrent Care Determinations](#) above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask our Customer Service Department for further help;
- You may file a voluntary appeal (discussed below);
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

External Reviews

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with us for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request

for external review, and must be submitted to the following address: Blue Cross and Blue Shield, Attention: Customer Service Department Appeals, P.O. Box 10744, Birmingham, AL 35202-0744.

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give us copies of this additional information to give us an opportunity to reconsider our denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both of us.

Expedited External Reviews for Urgent Pre-Service Claims

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling us at 1-833-749-1969 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. You must contact your plan administrator (normally your group) to determine whether this plan is covered by COBRA.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes.

If the group stops providing health care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your group to determine if you have further rights under COBRA.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your group continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your

COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your group that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse and Dependent Children

If you are covered under the plan as a spouse or a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The covered employee dies;
- The covered employee's hours of employment are reduced;
- The covered employee's employment ends for any reason other than his or her gross misconduct;
- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.

When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time. If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

If your coverage is canceled in anticipation of divorce and a divorce later occurs, the divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your coverage was canceled in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce).

Extensions of COBRA for Disability

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the

29-month period. See the following discussion under [Extensions of COBRA for Second Qualifying Events](#) for more information about this.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

Extensions of COBRA for Second Qualifying Events

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

Notice Procedures

If you do not follow these notice procedures or if you do not give the plan administrator notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security's disability determination.

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the plan administrator at the address listed under [Administrative Information](#) in the [Statement of ERISA Rights](#) section. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security's disability determination, if you are instructed to send your premiums to Blue Cross, you must mail your notice to ThrivePass at the following address: P.O. Box 24770, Seattle, WA 98124-0770, or fax your notice to Blue Cross at 205-220-6884 or 1-888-810-6884 (toll-free). If you do not send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to the plan administrator at the address listed under [Administrative Information](#) in the [Statement of ERISA Rights](#) section. Your notice must also include a copy of Social Security's disability determination. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security's disability determination as explained above.

Medicare and COBRA Coverage

You should consider whether it is beneficial to purchase COBRA coverage. After you retire or otherwise have a qualifying event under COBRA, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage after such qualifying event will not cover most of your hospital, medical and prescription drug expenses. Call the benefits coordinator at your group for more information about this.

If you think you will need both Medicare and COBRA after your retirement or other qualifying event under COBRA, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your retirement, or other qualifying event under COBRA. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire or have another qualifying event under COBRA. However, if your covered family members become enrolled in Medicare after electing COBRA, their COBRA coverage will end. See the [Early Termination of COBRA](#) section of this booklet for more information about this.

Electing COBRA

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the group notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the group.

Once the group has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

Early Termination of COBRA

Your COBRA coverage will terminate early if any of the following events occurs:

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing health care through Blue Cross, you will cease to receive any benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact your plan administrator. Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor.

RESPECTING YOUR PRIVACY

The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and healthcare operations and to put in place appropriate safeguards to protect your protected health information. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your group's human resources office.

Disclosures of Protected Health Information to the Plan Sponsor:

In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your group). Following are circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Human Resources Department

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information:

As a business associate of the plan, we (Blue Cross and Blue Shield of Minnesota) have an agreement with the plan that allows us to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious (in the case of claims covered by Section 502(a) of ERISA) or correct using the standard of review set forth in any applicable arbitration provisions of this booklet.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 10527, Birmingham, Alabama 35202-0500.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will be reflected in your claims report.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

Governing Law

The law governing the plan and all rights and obligations related to the plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Minnesota, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.

Termination of Benefits and Termination of the Plan

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

Changes in the Plan

Subject to any conditions or restrictions in our contract with the group, any and all of the provisions of the plan may be amended by the group at any time by an instrument in writing. In many cases, this instrument will consist of a new booklet (including any riders or supplements to the booklet) that we have prepared and sent to the group in draft format. This means that from time to time the benefit booklet you have in your possession may not be the most current. If you have any question whether your booklet is up to date, you should contact your group. Any fiduciary obligation to notify you of changes in the plan belongs to the group, not to us.

The new benefit booklet (including any riders or supplements to the booklet) will state the effective date applicable to it. In some cases, this effective date may be retroactive to the first day of the plan year to which the changes relate. The changes will apply to all benefits for services you receive on or after the stated effective date.

Except as otherwise provided in the contract, no representative, employee, or agent of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents.

No Assignment

As discussed in more detail in the [Claims and Appeals](#) section of this booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form or go to coupehealth.com, then log in and go to Benefits> Employer Benefits> Library> Documents to download and print the form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider—even if you have assigned payment of your claim to someone else. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident.

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

In-Network Providers: Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See [Out-of-Area Services](#), earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Minnesota.

Out-of-Network Providers: In accordance with Blue Cross's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources), or in accordance with applicable Federal law. In other cases, Blue Cross determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;

- The relative complexity of the service;
- The in-network allowance in Minnesota for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For services provided by certain out-of-network providers, the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

For out-of-network emergency services for medical emergencies or for air ambulance services, the allowed amount will be determined in accordance with the requirements of the applicable Federal law.

Ambulatory Surgical Center: A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

Blue Cross: Blue Cross and Blue Shield of Minnesota, except where the context designates otherwise.

BlueCard Program: An arrangement among Blue Cross and/or Blue Shield plans by which a member of one Blue Cross and/or Blue Shield plan receives benefits available through another Blue Cross and/or Blue Shield plan located in the area where services occur. The BlueCard program is explained in more detail in other sections of this booklet, such as [In-Network Benefits](#) and [Out-of-Area Services](#).

Claims administrator: Blue Cross and Blue Shield of Minnesota (Blue Cross)

Contract: Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

Cosmetic Surgery: Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma, or birth defect. For important information on cosmetic surgery, see the exclusion under [Health Benefit Exclusions](#) for cosmetic surgery.

Custodial Care: Care primarily to provide room and board for a person who is mentally or physically disabled.

Diagnostic: Services performed in response to signs or symptoms of illness, condition, or disease or in some cases where there is family history of illness, condition, or disease.

Durable Medical Equipment (DME): Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

General Hospital: Any institution that is classified by us as a "general" hospital using, as we deem applicable, generally available sources of information.

Group: The employer or other organization that has contracted with us to provide or administer group health benefits pursuant to the plan.

Habilitative Services: Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

Implantables: An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

In-Network Provider: See the [In-Network Benefits](#) subsection of the Overview of the Plan section of the booklet.

Inpatient: A registered bed patient in a hospital; provided that we reserve the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in [Inpatient Hospital Benefits](#) and [Outpatient Hospital Benefits](#).

Intensive Outpatient: Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of three hours per day at least three days per week with active psychosocial treatment and medication management as needed.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Lifetime Maximum: The cumulative maximum payable for covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health care plans with the employer.

Medical Emergency: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it. If a

service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational"; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Member: You or your eligible dependent who has coverage under the plan.

Mental Health Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they are caused, based, or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Out-of-Network Provider: A provider who is not an in-network provider.

Outpatient: A patient who is not a registered bed patient of a hospital. For example, a patient receiving services in the outpatient department of a hospital or in a physician's office is an outpatient; provided that we reserve the right in appropriate cases to reclassify outpatient services as inpatient stays, as explained above in [Inpatient Hospital Benefits](#) and [Outpatient Hospital Benefits](#).

Partial Hospitalization: Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of six hours per day, five days per week with active psychosocial treatment and medication management as needed.

Physician: Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

Plan: The plan is the group health benefit plan of the group, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the group, as amended;

- Any benefit matrices upon which we have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that we are treating as operative. By “operative,” we mean that we have provided a draft of the booklet to the group that will serve as the primary, but not the sole, instrument upon which we base our administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan’s members.

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were incurred. Unless the context requires otherwise, the terms “plan” and “contract” have the same meaning.

Plan Administrator: The group that sponsors the plan and is responsible for its overall administration. If the plan is covered under ERISA, the group referred to in this definition is the “administrator” and “sponsor” of the plan within the meaning of section 3(16) of ERISA.

Precertification: The procedures used to determine the medical necessity of the treatment prior to the service.

Pregnancy: The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body – usually, but not always, in the uterus – and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Preventive or Routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Private Duty Nursing: A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

Psychiatric Specialty Hospital: An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

Rehabilitative Services: Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Residential Treatment: Continuous 24 hour per day care provided at live-in facility for mental health or substance abuse disorders.

Skilled Nursing Facility: Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

Substance Abuse: The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

Substance Abuse Facility: Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that provides outpatient substance abuse services.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider. Teleconsultations include consultations by e-mail or other electronic means.

We, Us, Our: Blue Cross and Blue Shield of Minnesota.

You, Your: The covered members as shown by the context.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of

Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information

The following information is provided pursuant to the requirements of ERISA:

- The plan's official name is: Blue Cross and Blue Shield of Minnesota Group Healthcare Plan.
- The plan sponsor and plan administrator is the group. The group is responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The plan number assigned by the plan sponsor is: 501.
- The IRS Employer Identification Number (EIN) of the sponsor is: 41-0984460.
- The plan provides hospital and medical benefits as administered under an administrative services agreement between Blue Cross and the group. Blue Cross has complete discretion to interpret and administer the provisions of the plan. Blue Cross provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The administrative functions performed by Blue Cross include paying claims, determining medical necessity, etc. The plan benefits are self-insured.
- The agent for legal process is the group.
- The records of the health plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.
- The group currently intends to continue the plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.
- This is an employer-employee shared cost plan. The sources of the contributions to this plan are currently the group and the employee in relative amounts as determined by the group from time to time. While the group may change its level of contribution at any time, the group must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the group in writing and will constitute a part of this plan. Your contribution is determined by the group based on the plan's experience and other factors.
- Plan Administrator Contact Information:

Please mail COBRA notices to your plan administrator at the following address:

Attention: Employee Benefits (COBRA)
ThrivePass
P.O. Box 24770
Seattle, Washington 98124-0770

Blue Cross and Blue Shield
Birmingham Service Center
P.O. Box 188
Birmingham, Alabama 35201

Customer Service Department:

1-833-749-1969 (TTY 711) toll-free

Preadmission Certification:

1-833-749-1967 toll free

Website:

coupehealth.com

Identification (ID) Card

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

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Health Plan

03/2023