INDIVIDUAL

Blue Plus Southeast MN

HEALTH PLAN BENEFIT BOOKLET

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

PLEASE READ YOUR BENEFIT BOOKLET CAREFULLY

RIGHT TO CANCEL

You may cancel this benefit booklet by delivering or mailing a written notice to Blue Plus, P.O. Box 982801, El Paso, Texas 79998-2801 or your Blue Plus Agent. In addition, you must return the benefit booklet before midnight of the 10th day after the date you receive the benefit booklet. All materials must be properly addressed and postage prepaid. The benefit booklet will then be considered void from the beginning. Blue Plus must return all payments (including any fees or charges if applicable) made for this benefit booklet within 10 days after receiving notice of cancellation and the returned benefit booklet.

Please read the copy of the application attached to your benefit booklet. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to us within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance benefit booklet. The insurance benefit booklet was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete. This agreement is a legal agreement between the contractholder and Blue Plus.

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

Because of our concerns for the environment, this document is entirely recyclable as business office paper. When you no longer need it, recycle if possible.

LANGUAGE ACCESS SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

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

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

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

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

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

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

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

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

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

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

INDEPENDENT CORPORATION

Subscriber hereby expressly acknowledge their understanding that this agreement constitutes a contract solely between Subscriber and Blue Plus, which 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 "Association") permitting Blue Plus to use Service Marks in the state of Minnesota, and that Blue Plus is not contracting as the agent of the Association. Subscriber further acknowledge and agree that they have not entered into agreement based upon representations by any person other than Blue Plus and that no person, entity, or organization other than Blue Plus shall be accountable or liable to Subscriber for any of Blue Plus obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Plus other than those obligations created under the provisions of this agreement.

ACCEPTANCE OF THE CONTRACT

Payment to Blue Plus by the Subscriber will signify the Subscriber's acceptance of all terms, conditions, and obligations of this contract. Acceptance will be effective on the effective date of this contract.

IN WITNESS WHEREOF, our President and Assistant Secretary hereby sign your contract.

Monica R. Engel

Monica Engel
President and CEO

Laura Tongue

Laura Tongue
Assistant Secretary

QUESTIONS?

Call Us	Our Customer Service staff is available to answer questions about your coverage. Interpreter services are available to assist you if needed. This includes spoken language and hearing interpreters. Monday through Friday: 8:00 a.m. - 6:00 p.m. United States Central Time Hours are subject to change without prior notice. Toll-free 1-800-531-6685
Visit Us	**Duluth** 425 W. Superior Street, Suite 1060 Duluth, MN 55802 Telephone: 218-529-9199 TDD/TYY users call 711 **Roseville** Crossroads of Roseville 1647B County Road B2 West Roseville, MN 55113 Telephone: 651-726-1100 TDD/TTY users call 711 **Edina** Yorkdale Shoppes 6807 York Avenue South Edina, MN 55435 Telephone: 952-967-2750 TDD/TTY users call 711 **Virginia** 1301 West Chestnut Street Virginia, MN 55792 Telephone: 218-748-2700 TDD/TTY users call 711
Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmnonline.com
BlueCard Telephone Number	Toll-free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
BlueCard Website	www.bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
Pharmacy Telephone Number	Toll-free 1-800-509-0545 This number is used to locate a participating pharmacy

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

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WELCOME TO BLUE PLUS

On behalf of Blue Plus (referred to as "we", "us" or "our"), we are pleased to welcome you as a member. This benefit booklet provides you with the information you need to understand your Blue Plus health care plan. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, please call Customer Service at the telephone number listed on the back of your member identification (ID) card or log in to your Blue Plus member website at www.bluecrossmnonline.com.

Blue Plus does not issue individual coverage, such as this benefit booklet, through any arrangement with an employer. Blue Plus is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

This benefit booklet replaces all other contracts/benefit booklets you have received from us before the effective date. For purposes of this benefit booklet, "you" or "your" refers to the contractholder named on the identification (ID) card and other covered dependents. Contractholder is the person for whom we have provided coverage. Dependent is a covered dependent of the contractholder. Coverage under this benefit booklet for eligible members and dependents will begin as defined in "Eligibility."

This benefit booklet explains the health care plan, eligibility, notification procedures, covered services, and services that are not covered. Blue Plus is the insurer and the claims administrator. This contract is a fully-insured medical plan. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

All coverage and references to dependents in this benefit booklet are inapplicable for single coverage.

Please note: This benefit booklet is expected to return on average 80% of your premium dollar for health care. The lowest percentage permitted by state law for this health care plan is 80%.

BLUE PLUS IMPORTANT ENROLLEE INFORMATION AND BILL OF RIGHTS

Enrollee Information

COVERED SERVICES: Services provided by Blue Plus will be covered only if services are provided by participating Blue Plus providers or authorized by Blue Plus. Your benefit booklet defines what services are covered and describes procedures you must follow to obtain coverage.

PROVIDERS: Enrolling in Blue Plus does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of Blue Plus, you must choose among remaining Blue Plus providers.

PRIOR AUTHORIZATION: You are not required to get prior authorization from Blue Plus before using supplemental benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. This benefit booklet describes prior authorization procedures and the services for which prior authorization is required.

EMERGENCY SERVICES: Emergency services from providers who are not affiliated with Blue Plus will be covered only if proper procedures are followed. Your benefit booklet explains the procedures and benefits associated with emergency care from Blue Plus and non-Blue Plus providers.

EXCLUSIONS: Certain services or medical supplies are not covered. You should read your benefit booklet for detailed explanation of all exclusions.

TERMINATION: Your coverage may be terminated by you or us only under certain conditions. Your benefit booklet describes all reasons for termination of coverage.

NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating Blue Plus providers or authorized by Blue Plus. Certain services are covered only upon referral. Blue Plus will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify Blue Plus of the infant's birth and that you would like coverage. If your plan requires an additional coverage cost for each dependent, Blue Plus is entitled to all coverage costs due from the time of the infant's birth until the time you notify Blue Plus of the birth. Blue Plus may withhold payment of any health benefits for the newborn infant until any coverage costs you owe are paid.

PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in Blue Plus does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the benefit booklet year.

Blue Plus Member Rights and Responsibilities

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

- be treated with respect, dignity and privacy;
- have available and accessible medically necessary and appropriate covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care provider in decisions about your treatment;
- give your health care provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by Blue Plus and its health care providers in accordance with existing law;
- receive information about Blue Plus, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;

- have a resource at Blue Plus or at the clinic that you can contact with any concerns about services;
- file a complaint or appeal with Blue Plus and receive a prompt and fair review. In addition, you may file your appeal with the Minnesota Department of Health; and,
- initiate a legal proceeding when experiencing a problem with Blue Plus or its providers.

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

- know your health care plan benefits and requirements;
- provide, to the extent possible, information that Blue Plus and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your health care provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered; and,
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

BENEFIT OVERVIEW

Blue Plus of Minnesota

Your Benefits

This benefit booklet outlines the general coverage under this plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered. Please also review our "Not Covered" sections of the Benefit Charts and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate. The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, call Customer Service using the telephone number listed on the back of your member ID card.

Benefit Period

Your benefit period is based on a calendar year. The calendar year is a consecutive 12-month period beginning 12:00 a.m. on January 1 and ending 12:00 a.m. on the following January 1.

During this time, charges for covered services must be incurred in order to be eligible for payment by Blue Plus. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Payment of Premiums

Premiums for your coverage must be prepaid.

We have the right to change the rate for all contracts like yours and will notify you in advance of any changes. Your rate is the same as other contractholders of like age, and number of dependents who are covered under contracts like yours. We notify you of the new rate on the billing statement if the number of dependents covered under your contract changes.

Individual Blue Plus Southeast MN Health Plan Booklet

BENEFITS EFFECTIVE: 01/01/2021
POLICY YEAR AND RENEWAL DATE: 01/01/2022
FORM NUMBER: X21492-R3

Networks	
Your provider directory lists in-network providers in our service area and may change from time to time, at least once a month, including as providers or Blue Plus initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with Blue Plus, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan. If you receive a claim for services from a provider whose status changed from in-network to out-of-network, you may notify us and we will reprocess the claim as an in-network claim (as long as the provider accepts our in-network reimbursement rates and complies with any prior authorization or information requirements), if three criteria are met: (1) the claim is for a service provided after the network status change went into effect but before the change was posted in the online directory; (2) we did not notify you of the network status change before the service was provided; and, (3) we are unable to verify that the online directory displayed the correct network status on the date the service was provided. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or contact Customer Service at the telephone number listed on your member ID card.	
• **In-network participating providers**	Blue Plus Southeast MN network providers
• **Out-of-network participating providers** ▪ **In Minnesota**	Blue Cross and Blue Shield of Minnesota (Blue Cross) participating providers
▪ **Outside Minnesota**	BlueCard Traditional providers
• **In-network participating pharmacy providers**	Essential pharmacy network
For more information how your in-network works with your benefits, please refer to "How Your Program Works."	

Benefits	In-Network Providers	Out-of-Network Providers
General Provisions		
Deductible • Individual	You pay $4,200 per person per calendar year	You pay $20,000 per person per calendar year
• Family	You pay $12,600 per family per calendar year	You pay $30,000 per family per calendar year
Deductible - Embedded This plan has an embedded deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 50% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing up to the allowed amount to the end of the calendar year
Out-of-Pocket Limit – including Pharmacies • Individual	You pay $7,000 per person per calendar year	Not applicable
• Family	You pay $14,000 per family per calendar year	Not applicable
The following is included in the out-of-pocket maximum: • deductibles • coinsurance • prescription drug cost sharing		
Out-of-Pocket Limit – Embedded This plan has an embedded out-of-pocket limit. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.		
Prescription Drug Benefits	**In-Network Providers**	**Out-of-Network Providers**
Prescription Drugs:		
• Affordable Care Act (ACA) preventive covered prescription drugs. Please refer to www.bluecrossmnonline.com ("Member Log In" then "Coverage" then "Medical Benefits" then "Preventive Care") for the list of covered drugs	**Retail pharmacy:** You pay nothing **90dayRx participating retail pharmacy:** You pay nothing **Mail service pharmacy:** You pay nothing	**Retail pharmacy:** You pay nothing **90dayRx participating retail pharmacy:** NO COVERAGE **Mail service pharmacy:** NO COVERAGE

Benefits	In-Network Providers	Out-of-Network Providers
• BasicRx tier 1 prescription drugs	**Retail pharmacy:** You pay 20% coinsurance after deductible **90dayRx participating retail pharmacy:** You pay 20% coinsurance after deductible **Mail Service Participating Pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE
• BasicRx tier 2 prescription drugs	**Retail pharmacy:** You pay 20% coinsurance after deductible **90dayRx Participating Retail Pharmacy:** You pay 20% coinsurance after deductible **Mail service pharmacy:** You pay 20% coinsurance after deductible	NO COVERAGE
• BasicRx tier 3 prescription drugs	**Retail pharmacy:** You pay 40% coinsurance after deductible **90dayRx participating retail pharmacy:** You pay 40% coinsurance after deductible **Mail service pharmacy:** You pay 40% coinsurance after deductible	NO COVERAGE
• BasicRx tier 4 prescription drugs: ▪ designated specialty prescription drugs purchased through a specialty pharmacy network supplier	**Specialty pharmacy network supplier:** You pay 20% coinsurance after deductible	NO COVERAGE
• Retail pharmacy vaccine program ▪ certain eligible vaccines administered at a participating retail pharmacy	**Retail pharmacy:** You pay nothing	NO COVERAGE
• Insulin listed on tier 1 and tier 2 of the covered drug list are covered at zero cost-sharing.		

Annual Adjustment

The deductible, copays and out-of-pocket limit amounts may be subject to annual adjustments as permitted under law. These annual adjustments are effective on the annual renewal date.

Dependents

Dependent children, when added to the plan, are covered up to age 26. Disabled dependents are covered as specified in "Eligibility."

BENEFIT CHART

The health care plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copay amounts are described in the "Benefit Overview" section. In-network care is covered at a higher level of benefits than out-of-network care.

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

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

Benefit Descriptions

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

AMBULANCE

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

NOTES:

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

  when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
- Transportation and related emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. Please refer to "Terms You Should Know" for a definition of medical emergency.
- Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.

NOT COVERED:

- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. We will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs)
- travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein
- ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support
- transportation services, including ambulance services that are mainly for your convenience

BEHAVIORAL HEALTH MENTAL HEALTH CARE

Your mental health is just as important as your physical health. That is why your health care plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ individual/group/family therapy (office/in-home mental health services)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ assessment and diagnostic services ▪ neuropsychological examinations ▪ all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional health care services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based intensive outpatient programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility health care services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based intensive outpatient programs (IOP)	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/inpatient behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Based on the federal Mental Health Parity and Addiction Equity Act and Minnesota statutes, section 62Q.47, members have the right to parity in mental health and substance use disorder treatment. Generally, these laws provide that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and

NOTES:

- treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

- If your PCC determines that structured mental health treatment is not medically necessary and appropriate, you are entitled to a second opinion, paid by the plan, by a health care professional who is qualified in the diagnosis and treatment of the problem and who is not affiliated with us.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary and appropriate.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- Coverage is provided on the same basis as other benefits for treatment of emotionally disabled dependent children in a licensed residential behavioral health treatment facility. "Emotionally disabled child" shall include: "an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner; and seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation."
- For home health related services, please refer to "Home Health Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- You are covered for a full range of counseling and treatment services.
- Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient.
- Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your physician and include, but are not limited to: antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
- Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services that provide real-time interaction between a distant site physician/medical practitioner while the patient/member is present and participating in the televideo visit at an originating site.

NOT COVERED:

- services for or related for mental illness not listed in the most recent edition of the *International Classification of Diseases* (ICD) and *Diagnostic and Statistical Manual for Mental Disorders* (DSM)
- services for or related to intensive behavioral therapy programs, including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Intensive Behavioral Intervention (IBI), and Lovaas Therapy, for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including: autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified

BEHAVIORAL HEALTH MENTAL HEALTH CARE (continued)

NOT COVERED:

- court ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as specified under Minnesota law
- custodial care, nonskilled care, adult daycare or personal care attendants
- evaluations that are not performed for the purpose of diagnosing of treating mental health or substance use disorder conditions such as: custody evaluations, parenting assessments, education classes for DUI or DWI offences, competency evaluations, adoption home status, parental competency, and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care and lodging programs, halfway house services and skills training
- services for or related to marriage/couples counseling
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or, marriage/couples retreats, encounters, or seminars
- services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS) and except as provided herein
- services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning)
- services for the treatment of learning disabilities, except when medically necessary and appropriate and provided by an eligible health care provider
- services for therapeutic day care and therapeutic camp services

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services including: ▪ office visit ▪ individual and family therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ assessment and diagnostic services ▪ opioid treatment, including medication assisted treatment (MAT) ▪ all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Outpatient hospital/outpatient behavioral health treatment facility services including: ▪ intensive outpatient programs (IOP) and related aftercare services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient health care professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Inpatient hospital/residential behavioral health treatment facility charges for services including: ▪ all eligible inpatient services ▪ emergency holds	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- Based on the federal Mental Health Parity and Addiction Equity Act and Minnesota statutes, section 62Q.47, members have the right to parity in mental health and substance use disorder treatment. Generally, these laws provide that:
  - mental health and substance use disorder services are to be covered on the same basis as similar medical services;
  - cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
  - treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner while the patient/member is present and participating in the televideo visit at an originating site.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visits and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For home health related services, please refer to "Home Health Care."
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder and include the following:
  - inpatient hospital or substance use disorder treatment facility provider services for detoxification.

BEHAVIORAL HEALTH SUBSTANCE USE CARE (continued)

NOTES:

- substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services.
- outpatient hospital or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy.
- court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections.
- admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
- coverage includes medication assisted treatment (MAT) for opioid use disorder.

- For member questions and concerns please contact Customer Service at the telephone number listed on the back of your member ID card, or you may file a complaint with Blue Plus, or file a complaint with the Minnesota Department of Health.

NOT COVERED:

- services for substance use disorder or addictions that are not listed in the most recent edition of the *International Classification of Diseases* (ICD) and *Diagnostic and Statistical Manual for Mental Disorders* (DSM)
- custodial care, nonskilled care, adult daycare or personal care attendants
- court ordered services or confinements by a court or law enforcement officer that are not based on a behavioral health care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist as specified under Minnesota law
- evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and, parental competency and domestic violence programs
- services for or related to room and board for foster care, group homes, shelter care, and lodging programs, halfway house services and skills training
- substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition

CHIROPRACTIC CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Spinal manipulations – includes office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Other chiropractic services including therapies	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Physician Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; and, chiropractor time.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc.; and, all related material and products for these programs
- services for or related to therapeutic massage
- maintenance service
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition
- custodial care

DENTAL CARE

The Plan Covers	In-Network Providers	Out-of-Network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth if the treatment begins within 12 months of either the date of the injury or first date of coverage and is completed within 24 months of the first treatment • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Accident-related dental services, treatment and/or restoration of a sound natural tooth must be initiated within 12 months of the date of injury or within 12 months of your effective date of coverage under this plan. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services performed within 24 months from the date treatment or restoration is initiated are covered. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crown, fillings and bridges.
- The health care plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility services, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound and healthy natural tooth.
- Services for surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

NOT COVERED:

- services for or related to orthodontia, except as provided herein
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services, including bone grafts
- dental implants and associated services, except when related to services for cleft lip and palate that are scheduled or initiated prior to the member turning age 19

NOT COVERED:

- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein
- accident-related dental services initiated after 12 months from the date of injury or occurring more than 24 months after the date of initial treatment
- services for or related to replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as provided herein
- services for or related to oral surgery and anesthesia for removal of impacted teeth, removal of a tooth root without the removal of the whole tooth and root canal therapy, except as provided herein
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility services, and bone grafts, except as provided herein
- services, including dental splints, to treat bruxism
- services for routine dental care, except as provided herein

EMERGENCY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after in-network deductible	
• Outpatient hospital/facility charges to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after in-network deductible	

NOTES:

- As a member, you are covered at the higher, in-network level of benefits for emergency care received in or outside the provider network. This flexibility helps accommodate your needs when you need care immediately.
- In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. When determining if a situation is a medical emergency, we will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- Once the crisis has passed, call your physician to receive appropriate follow-up care
- For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
- For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
- Please refer to "Terms You Should Know" for a definition of medical emergency.

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: ▪ office visit ▪ counseling	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Gender affirming procedures for the treatment of gender dysphoria, including related preparation and follow-up treatment care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- For prescription drugs for the management of gender dysphoria, please refer to "Prescription Drugs."
- For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
- For more information contact Customer Service or visit www.bluecrossmn.com/gendercare.

NOT COVERED:

- treatment, services or supplies that are not medically necessary.

HOME HEALTH CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare or plan approved home health care agency including but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care	You pay 20% coinsurance after deductible	NO COVERAGE

NOTES:

- Home health care services are subject to a limit of 120 visits per person per calendar year. The one (1) home health care visit following early maternity discharge does not apply to the 120 visits limit.
- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.
- Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other pre-approved home health care agency consists of up to two (2) consecutive hours per date of service.
- Benefits for home infusion therapy and related home health care are listed under "Infusion Therapy."
- For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- services you receive from an out-of-network provider.
- homemaker services
- maintenance services

NOT COVERED:

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

HOSPICE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospice care for a terminal condition provided by a Medicare-approved hospice provider or other preapproved hospice, including: ▪ routine home care ▪ continuous home care ▪ inpatient Respite Care ▪ general Inpatient Care	You pay 20% coinsurance after deductible	NO COVERAGE

NOTES:

- Benefits are limited to members with a terminal condition (i.e., life expectancy of six (6) months or less). The member's primary physician must certify, in writing, a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program.
- Hospice program inpatient respite care is for the relief of the member's primary care giver and is limited to a maximum of five (5) consecutive days at a time.
- Home respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program.
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition
- Medical care services unrelated to the terminal condition under the hospice program are covered, but are separate from the hospice benefit.

NOT COVERED:

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

HOSPITAL INPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Hospital room and board and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs and medicines provided to you while you are an inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The health care plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition.
- The plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant or other kinds of transplants, please refer to "Transplant Coverage."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the benefit booklet:
  - potential donor testing;
  - donor evaluation and work-up; and,
  - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
  - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - diagnostic pathology consisting of laboratory and pathology tests;
  - diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Blue Plus;
  - allergy testing consisting of percutaneous, intracutaneous, and patch tests
- The plan covers telemedicine services, also be referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner while the patient/member is present and participating in the televideo visit at an originating site.

NOTES:

- The plan covers anesthesia and inpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or, has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.

NOT COVERED:

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

HOSPITAL OUTPATIENT CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Outpatient hospital/facility services, except as noted below • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Urgent care center visits ▪ facility billed services ▪ facility laboratory services ▪ facility diagnostic imaging services • Prescription drugs and medicines provided to you while you are an outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Laboratory services • Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Facility billed free-standing ambulatory surgical center services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- The health care plan covers anesthesia and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.
- Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and Services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.
- Coverage is provided for anesthesia, anesthesia supplies and devices rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.
- The plan covers outpatient palliative care for members with a new or established diagnosis of a progressive debilitating illness, including illness which may limit the patient's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOTES:

- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner while the patient/member is present and participating in the televideo visit at an originating site.

NOT COVERED:

- services for or related to bariatric surgery, except as provided herein
- services and prescription drugs for related to assisted fertilization

INFUSION THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Home infusion and suite infusion therapy services • Intravenous Solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Durable medical equipment • Medical/surgical supplies • Nursing services associated with infusion therapy to: ▪ train you or your caregiver ▪ monitor the home infusion therapy • Collection, analysis, and reporting of laboratory tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy	You pay 20% coinsurance after deductible	NO COVERAGE

NOTES:

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

NOT COVERED:

- services you receive from an out-of-network provider
- home infusion services or supplies not specifically listed as covered services
- nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy
- investigative or non-FDA approved drugs, except as required by law

MATERNITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prenatal hospital/facility provider services	You pay nothing	
• Prenatal professional services	You pay nothing	
• Health care professional services for: ▪ delivery in a hospital/facility ▪ examination of the newborn infant while the mother is an inpatient	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ postpartum care • office visit	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other eligible professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Hospital/facility services for: ▪ delivery in a hospital/facility ▪ postpartum care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- If you think you are pregnant, you may contact your physician or go to an in-network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital.
- Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
- Complications of pregnancy - physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
- Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.
- Nursery care - covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. In order to avoid claim delays, we request that you submit payment of all required premiums and written application within 30 days after birth. Please refer to "Adding New Dependents" for further eligibility information regarding when the newborn's coverage will begin if the newborn is added to the health care plan.
- Under federal law, this health care plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
  - inpatient hospital coverage for the **mother** if covered under this health care plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health care plan. Please refer to "Home Health Care."
  - inpatient hospital coverage for **newborn**, if added to the health care plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health care plan. Please refer to "Home Health Care."
- Under federal law, this health care plan may require that a provider obtain authorization for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- Please refer to "Eligibility" to determine when the newborn's coverage will begin if the newborn is added to the plan.

NOTES:

- 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."

NOT COVERED:

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

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds • Custom foot orthoses if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet • Equipment and devices for habilitative or rehabilitative services • Medical supplies, including splints, surgical stockings, casts, and dressings • Equipment and supplies for diabetes treatment including, but not limited to: ▪ insulin infusion devices, ▪ blood glucose monitors ▪ monitor supplies • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for phenylketonuria (PKU) when recommended by a physician • Amino acid-based elemental formula • Corrective lenses for aphakia or keratoconus • Eyeglasses/lenses after cataract surgery (purchased within 24 months of cataract surgery) • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per person per calendar year. • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

MEDICAL EQUIPMENT, PROSTHETICS, AND SUPPLIES (continued)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Medically necessary and appropriate corrective lenses for children age 18 and younger as follows: ▪ eyeglasses (lenses and frames); maximum of one (1) standard frame and one (1) pair of lenses per person per calendar year (see NOTES below); or, ▪ contact lenses; maximum of one (1) pair of contact lenses or one (1) year supply of disposable contact lenses per person per calendar year; and, ▪ eligible low vision aids prescribed by eligible ophthalmologists or optometrists specializing in low vision care	You pay 20% coinsurance after deductible	NO COVERAGE

NOTES:

- You are required to obtain prior authorization for durable medical equipment when you use nonparticipating providers in Minnesota and any Provider outside of Minnesota. Please refer to www.bluecrossmnonline.com (click on the "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources") or call Customer Service at the telephone number listed on the back of your member ID card.
- Coverage includes the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.
- Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a health care provider legally authorized to prescribe such items under the law:
  - equipment and supplies: all physician prescribed medically necessary and appropriate equipment and supplies, including but not limited to, blood glucose monitors, monitor supplies, and insulin infusion devices.
- Coverage for eligible orthotic devices includes purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- The rental or, upon approval by Blue Plus, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a health care provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.
- Amino acid-based elemental formula, a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for infants or children with specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. An infant or child may be placed on an amino acid-based formula if he/she is unable to digest or tolerate whole proteins found in other formulas, due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino and E028 Neocate Splash.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Durable medical equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For coverage of insulin and diabetic supplies, please refer to "Prescription Drugs."
- For hearing aid examination services, please refer to "Office Visit and Professional Services."
- Participating providers maintain a "collection" of standard frames to choose from corrective lenses for children age 18 and younger premium frames that are outside of the "standard collection" are not covered.

NOT COVERED:

- scalp/cranial hair prostheses (wigs) for any diagnosis other than alopecia areata
- foot orthoses, except as provided herein
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as provided herein
- charges for the rental of a manual breast pump
- charges for an electric breast pump
- personal and convenience items or items provided at levels which exceed our determination of medically necessary and appropriate for durable medical equipment, supplies, and prosthetics
- services or supplies that are primarily and customarily used for a nonmedical purposes, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- replacement of properly functioning durable medical equipment
- duplicate equipment, prosthetics, or supplies
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein
- charges for corrective lenses (including frames) for children age 18 and younger from an out-of-network provider
- charges for premium frames for corrective lenses for children age 18 and younger that are not included in the "standard collection"
- services for or related to hearing aids or devices, except a provided herein
- charges for devices for maintenance services

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Physician office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• E-visits • Telephone consultations	You pay nothing	You pay 50% coinsurance after deductible
• Urgent care center visits for illness/injury ▪ professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Retail health clinic ▪ office visits	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
▪ all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Allergy extract and allergy injections including: ▪ allergy testing ▪ allergy serum ▪ allergy injections	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Professional billed services received at a free-standing ambulatory surgical center	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Medically necessary and appropriate low vision evaluation and follow-up care for children age 18 and younger provided by eligible Ophthalmologists or Optometrists specializing in low vision care	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

OFFICE VISIT AND PROFESSIONAL SERVICES (continued)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery • Assistant surgeon or registered nurse first assistant • Kidney and cornea transplants • Therapeutic injections (e.g., drugs, cellular therapy) administered by a health care provider in the diagnosis, prevention and treatment of an injury or illness, provided that they are not "usually self-administered" by a member • Palliative care • all other professional services	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of licensure.
- If more than one (1) surgical procedure is performed during the same operative session, the benefit booklet covers the surgical procedures based on the allowed amount for each procedure. The benefit booklet does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- You are entitled to receive care for the following services at the in-network level of benefits from any qualified licensed provider:
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; or,
  - testing of AIDS or other HIV-related conditions.
- For kidney transplants done in conjunction with an eligible major transplant, please refer to "Transplant."
- The plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the plan:
  - potential donor testing;
  - donor evaluation and workup; and,
  - hospital and professional services related to organ procurement.
- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and Blue Plus. Please verify with your provider that form 2728 has been completed and submitted.

NOTES:

- Eligible therapeutic injections, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider are eligible under the "Office Visit and Professional Services" benefit. For therapeutic injectable medications billed by a pharmacy or specialty drugs billed by the participating specialty pharmacy network supplier, please refer to "Prescription Drugs". For specialty drugs that are administered in a clinic or an outpatient hospital, your health care provider may be required to obtain the specialty drugs from a designated vendor.

  Therapeutic injections includes coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- The benefit booklet covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
- The plan covers hearing aid examinations/fitting/adjustments for children age 18 and younger.
- The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The plan covers telemedicine services, also referred to as televideo consultations or telehealth services, that provide real-time interaction between a distant site physician/medical practitioner while the patient/member is present and participating in the televideo visit at an originating site.
- E-Visit is a patient initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital/facility provider. Retail health clinics are staffed by eligible nurse practitioners or other eligible health care providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the medical benefit. Medical policy guidelines are available on our website at www.bluecrossmnonline.com or contact Customer Service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medical necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override of step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmnonline.com or contact Customer Service. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the drug if it is a covered prescription drug under your plan.
- For self-administered prescription medications/drugs, please refer to "Prescription Drugs."
- The plan covers services for or related to growth hormone replacement therapy.

NOT COVERED:

- services for giving injections that can be self-administered

NOT COVERED:

- services for autopsies
- services for or related to bariatric surgery, except as provided herein
- services for or related to the LINX™ Reflux Management System (considered investigative) for the treatment of gastroesophageal reflux disease (GERD)
- repair of scars and blemishes on skin surfaces
- services provided during an e-visit for the sole purpose of: scheduling appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- out-of-network provider initiated communications
- separate services for pre-operative and post-operative care for surgery billed by an out-of-network provider
- services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein
- services for or related to travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this benefit booklet
- kidney donor expenses when the recipient not covered under this benefit booklet
- services and prescription drugs for or related to assisted fertilization
- services for or related to reversal of sterilization
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible
• Habilitative and rehabilitative therapies from a physical therapist, occupational therapist, speech or language pathologist	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Office visits may include a physical therapy evaluation or re-evaluation; occupational therapy evaluation or re-evaluation; speech or swallowing evaluation
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

NOT COVERED:

- services for or related to vocational rehabilitation (defined as service provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and appropriate and provided by an eligible health care provider
- services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate

PRESCRIPTION DRUGS

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Prescription drugs ▪ prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips, needles and syringes, lancets ▪ prescription injectable drugs that are self-administered and do not require the services of a health care professional, except for designated specialty drugs (see NOTES below) ▪ Affordable Care Act (ACA) preventive covered prescription drugs. Please refer to www.bluecrossmnonline.com ("Member log in" then "Coverage" then "Preventive Care") for the list of covered drugs ▪ FDA-approved tobacco cessation drugs and products, subject to limitations below ▪ prescription prenatal vitamins ▪ prescription pediatric multivitamins with fluoride ▪ prescribed over-the-counter nicotine replacement products ▪ oral, transdermal, injectable, and barrier contraceptives for women of reproductive capacity, not otherwise described below ▪ designated specialty drugs purchased through a participating specialty pharmacy network supplier ▪ retail pharmacy vaccine program • certain eligible vaccines administered at a participating retail pharmacy (see NOTES below)	Please refer to "Prescription Drug Benefits" in "Benefit Overview."	Please refer to "Prescription Drug Benefits" in "Benefit Overview."

NOTES:

- Insulin listed on tier 1 and tier 2 of the covered drug list are covered at zero cost-sharing.
- Covered prescription drugs include drugs listed in your health care plan's covered drug list; including compounded medications, consisting of the mixture of at least two or more FDA-approved prescription drugs/medications. (Please refer to "Terms You Should Know").
- You must present your member ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your member ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing we have negotiated with participating pharmacies for that prescription drug.

NOTES:

- The Blue Plus covered drug list is a list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Plus Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. This list can change throughout the year. Enrollees affected by a higher cost prescription drug tier change or removal of a drug from the covered drug list will receive 30 days advance written notice of the change. If the prescribing health care provider believes that you need coverage for a prescription drug subject to changes in your specified covered drug list, there is a process to request an exception. The health care provider must submit a written Exception request to us.
- Eligible prescription drugs are covered when you purchase them through the pharmacy network applicable to your health care plan, except as provided herein. For convenience and choice, in-network pharmacies include both major chains and independent stores. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- Blue Plus chooses which drugs are on its drug lists, or excluded from its drug lists, based on numerous factors including their quality, safety and effectiveness, and overall cost. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a drug list while the generic of the same drug is excluded from a drug list.
- To receive a copy of your covered drug list visit www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service at the telephone number listed on the back of your member ID card.
- The drug list is subject to periodic review and modification by Blue Plus or a designated committee of physicians and pharmacists.
- A **retail pharmacy** is a licensed pharmacy that you can physically enter to obtain a prescription drug. Eligible prescription drugs and diabetic supplies are generally covered up to a 31-day supply.
- **90dayRx** includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy that dispenses prescription drugs through the U.S. Mail. Eligible prescription drugs are dispensed up to a 93-day authorized supply of ongoing, long-term prescription drugs.
- Benefits are provided for a range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- Benefits are provided for designated ACA preventive drugs with a prescription which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
- For more information regarding contraceptive or ACA preventive prescription drug coverage, please visit www.bluecrossmnonline.com ("Member Log in" then "Coverage" then "Medical benefits" then "Preventive Care") or contact Customer Service at the telephone number listed on the back of your member ID card.
- Blue Plus applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications where a $0 member cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service at the telephone number listed on the back of your member ID card. If your prescribing health care professional determines that none of the $0 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through www.bluecrossmn.com/basicrxindividualsmallgroup2021 (select "Forms" then "Coverage Exception Form"). If the exception request is approved, the contraceptive medications are eligible for $0 member cost-sharing.

NOTES:

- Covered prescription drugs include:
  - if the prescribing health care professional believes that you need coverage for a clinically appropriate drug that is not covered by this plan, there is a process to request an exception. Please refer to "Exception Requests for Clinically Appropriate Prescription Drugs Not Covered by this Plan" in "Filing a Claim and Review Procedure";
  - those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
  - legend prescription drugs under applicable state law and dispensed by a licensed pharmacist; and,
  - certain prescription drugs that may require prior authorization from Blue Plus.
- Your designated covered drug list also includes selected specialty prescription drugs within, but not limited to, the following prescription drug classifications only when such prescription drugs are covered medications and are dispensed through exclusive specialty pharmacy network supplier. Specialty prescription drugs are designated complex injectable and oral drugs generally covered up to a 31-day supply that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty prescription drugs are prescription drugs including, but not limited to prescription drugs used for: growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and, hemophilia. A current list of eligible designated specialty prescription drugs and suppliers is available at www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service at the telephone number listed on the back of your member ID card. Specialty prescription drugs are not available through 90dayRx. Specialty prescription drugs may be ordered by a health care provider on your behalf or you may submit the prescription order directly to the specialty pharmacy network supplier.
- The retail pharmacy vaccine program allows you the opportunity to receive certain otherwise eligible vaccines at designated participating retail pharmacies subject to your prescription drug cost-sharing. This program is in addition to your current vaccine benefit administered through your clinic/physician's office. A list of eligible vaccines under this program and designated participating pharmacies is available on our website at www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service.
- If you are prescribed a medication subject to step therapy, another eligible medication that is safe, more clinically effective, and in some cases more cost effective must have been prescribed and tried before the medication subject to step therapy will be paid under the prescription drug benefit. Step therapy prescription drug categories are available on our website at www.bluecrossmnonline.com or contact Customer Service at the telephone number listed on the back of your member ID card. At your written request, we will provide you the criteria that we use to determine the medically necessity and appropriateness of a prescription drug that is subject to step therapy. If you or your prescribing health care provider believes that you need coverage for a prescription drug that is subject to the step therapy provision, an override from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available on our website at www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service at the telephone number listed on the back of your member ID card. If the step therapy override request meets one of the legally required conditions, we will grant the request, override the step therapy requirement, and cover the prescription drug if it is a covered prescription drug under your plan.
- Benefits are provided for the following drugs when prescribed and dispensed by a licensed pharmacist, in accordance with state law, in the same way coverage would apply had the drugs been prescribed by a health care professional: self-administered hormonal contraceptives, nicotine replacement medications, and opiate antagonists for the treatment of an acute opiate overdose.

NOTES:

- If you are prescribed a prescription drug when there is an equivalent lower cost prescription drug, you will also pay the difference in cost between the prescribed prescription drug and the lower cost prescription drug, in addition to the applicable member cost-sharing. When you have reached your out-of-pocket limit, you still pay the difference in cost between the higher cost prescribed prescription drug and the equivalent lower cost prescription drug, even though you are no longer responsible for the applicable prescription drug member cost-sharing. Your payment is the price difference between the higher cost prescription drug and lower cost prescription drug in addition to the cost-sharing amounts that apply. Certain prescription drugs are not covered when an equivalent lower cost prescription drug is available. You are also responsible for the payment differential when a lower cost prescription drug is authorized by the physician and you purchase an equivalent higher cost prescription drug. This includes medications that have been approved for coverage, such as through the exception or prior authorization process. For a list of covered drugs, visit www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service at the telephone number listed on the back of your member ID card.
- The plan will cover the full range of prescription tobacco cessation drugs and products and over-the counter tobacco cessation drugs and products with a prescription. Medical management (such as quantity limitations, coverage only for specific drugs or product(s) within a given type of tobacco cessation medication, etc.) may apply.
- The health care plan will cover off-label prescription drugs used for cancer treatment as specified by law. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
- Coverage is provided for oral chemotherapy medications on the same basis as all other eligible prescription drugs
- Antipsychotic prescription drugs not included on your covered drug list prescribed to treat emotional disturbance or mental illness will be covered at the same level as your covered prescription drugs if the prescribing health care provider indicates that the prescription must be "Dispense As Written" (DAW) and certifies in writing to us that he/she has determined that the prescription drug prescribed will best treat your condition.
  - If you are taking a prescription drug to treat mental illness or emotional disturbance that has effectively treated your condition, the prescription drug will be covered up to one (1) year when the prescription drug is removed from your covered drug list, and if:
    - you have been treated with the prescription drug for 90 days prior to a change in your covered drug list or a change in your health care plan;
    - the prescribing health care provider indicates that the prescription must be DAW; and,
    - the prescribing health care provider certifies in writing to us that the prescription drug prescribed will best treat your condition.
  - The continuing care benefit will be extended annually if the prescribing health care provider indicates that the prescription must be DAW and certifies in writing to us that the prescription drug prescribed will best treat your condition.
- If the prescribing health care provider believes that you need coverage for a prescription drug that is not on your covered drug list, there is a process to request an exception. The health care provider must submit a written exception request to us. This request must indicate that the covered prescription drug(s) causes an adverse reaction or is contraindicated for the member, or demonstrate that the noncovered prescription drug must be "DAW" to provide maximum benefit to the member.
- Purchases for amino acid-based elemental formula through a pharmacy are subject to the applicable prescription drug member cost-sharing under "Prescription Drugs" in "Benefit Overview."
- Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
- To locate a participating Pharmacy in your area, call the pharmacy information number provided in the "Customer Service" section.
- For prescription drugs dispensed and used during a covered hospital stay, please refer to "Hospital Inpatient Care."
- For supplies or appliances, except as provided in this "Benefit Chart," please refer to "Medical Equipment and Supplies."

NOTES:

- When you pay for your prescription drugs, insulin, and drug therapy supplies yourself, you are required to submit the drug receipt(s) with a claim form for reimbursement.
- There may be circumstances where early or extended prescription drug refills are available. Please contact Customer Service at the telephone number listed on the back of your member ID card for further information. Restrictions apply.
- We may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain prescription drugs covered under the health care plan. Such discounts are the sole property of Blue Plus and will not be considered in calculating any coinsurance, copay, deductible, or benefit maximums, except as required by law.

NOT COVERED:

- any services by any pharmacy provider or pharmacist, except as provided herein
- any prescription for more than the retail days supply or 90dayRx days supply as outlined in the "Benefit Overview" section, except as provided herein
- charges for any drug purchased through mail order but not dispensed by a designated mail order pharmacy provider
- prescription drugs not included on your covered drug list, except as provided herein
- specialty drugs not purchased through a specialty pharmacy network supplier
- blenderized food, baby food, or regular shelf food when used with an enteral system
- milk or soy-based infant formula with intact proteins
- any formula (standard and specialized), when used for the convenience of you or your family members
- any substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding and as provided herein
- drugs removed from the covered drug list due to safety reasons may not be covered
- over-the-counter (OTC) drugs, except as provided herein
- investigative or non-FDA approved drugs, except as provided by law
- vitamin or dietary supplements, except as provided herein
- tobacco cessation drugs and products without a prescription
- services for or related to tobacco cessation drugs and program fees and/or supplies, except as provided herein
- semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders
- medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. Covered medical devices are generally submitted and reimbursed under your medical benefits. Please refer to "Medical Equipment and Supplies"
- services and prescription drugs for or related to assisted fertilization
- lifestyle medications/drugs including, but not limited to:
  - prescription drugs for the treatment of sexual dysfunction including, but not limited to erectile dysfunction
  - cosmetic alteration medications/drugs
  - weight loss medications/drugs
- services you receive from a nonparticipating pharmacy, except as provided herein

PREVENTIVE CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
Preventive care services from health care professionals, outpatient hospitals/facilities, and medical equipment suppliers in accordance with a predefined schedule based on age, sex and certain risk factors which are included in the A and B recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). This list of services is not exhaustive. For more information on all covered preventive services you can access more information at www.bluecrossmnonline.com or contact Customer Service:		
• Adults and children age 6 and older including, but not limited to: ▪ cancer screenings required by law such as: • mammograms, 2 dimensional (2-D) or three dimensional (3-D), annual routine and medically necessary and appropriate • papanicolaou (PAP) test • flexible sigmoidoscopies and/or screening fiberoptic colonoscopies • fecal occult blood testing • prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages • surveillance tests for ovarian cancer (CA 125 tumor marker, trans-vaginal ultrasound, pelvic examination) ▪ routine physical examinations ▪ routine gynecological examinations ▪ adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease ▪ hearing screening ▪ laboratory screening and testing ▪ diagnostic services and procedures ▪ routine sedation for colonoscopies ▪ screening and counseling for tobacco cessation ▪ folic acid supplement for women planning to become pregnant ▪ depression screening for adults and children ▪ routine vision examination from age 6 through age 18 ▪ Folic acid supplement for women planning to become pregnant ▪ Breast feeding comprehensive support and counseling, including purchase of manual breast pump ▪ Obesity screening and counseling	You pay nothing	You pay 50% coinsurance after deductible

PREVENTIVE CARE (continued)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Infants and children ▪ routine physical examinations from birth to age 6 ▪ pediatric immunizations from birth to age 18 ▪ diagnostic services and procedures from birth to age 6 ▪ laboratory screening and testing from birth to age 6 ▪ developmental assessments from birth to age 6 ▪ routine vision screening from birth to age 6	You pay nothing	

NOTES:

- Preventive care services are consistent with state and federal statutes, regulations, and related guidance.
- Blue Plus periodically reviews the schedule of covered services based on the requirements of the Patient Protection and Affordable Care Act of 2010, and recommendations from USPSTF, ACIP, HRSA, and the IRS. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. This list of services is not exhaustive, and this list could change, as recommendations and criteria change. For a current schedule of covered services, log onto your Blue Plus member website at www.bluecrossmnonline.com ("Member Log In" then "Coverage" then "Medical Benefits" then "Preventive Care"), or call Customer Service at the telephone number listed on the back of your member ID card.
- Benefits are provided for "child health supervision services," which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. We will reimburse five (5) child health supervision visits from birth to 12 months, three (3) child health supervision visits from 12 months to 24 months, and once a year from 24 months to 72 months.
- Routine physical examinations including a complete medical history for adults, and other items and services. Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.
- For more information regarding preventive care services, please visit www.bluecrossmnonline.com ("Member Log In" then "Coverage" then "Medical Benefits" then "Preventive Care") or contact Customer Service.
- You are entitled to receive care at the in-network level for screening for sexually transmitted disease or HIV.
- Benefits are provided for the *purchase* of a manual breast pump.
- Adult preventive care services are limited to those on Blue Plus' preventive schedule and the women's health preventive schedule. Gender, age and frequency limits may apply.
- Pediatric preventive care services are limited to those on Blue Plus' preventive schedule. Gender, age and frequency limits may apply.
- Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA. For more information regarding elective sterilization coverage please visit www.bluecrossmnonline.com ("Member Log In" then "Coverage" then "Medical Benefits" then "Preventive Care") or contact Customer Service.

NOTES:

- Benefits are provided for a range of FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Please refer to "Prescription Drugs and Insulin" for outpatient drug coverage.
- Services for complications related to female contraceptive drugs, devices, and services for women reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
- Services to treat an illness/injury diagnosed as a result of preventive care services or preventive care services in excess of United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, or Health Resources and Services Administration (HRSA) recommendations and criteria may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
- All female members, regardless of age, are covered for routine gynecological exams, including a pelvic and clinical breast examination.
- Mammogram screening benefits are provided for a routine mammogram screening for all female members, 2 dimensional (2-D) or 3 dimensional (3-D).
- Benefits are provided to eligible dependent children for pediatric immunizations.
- Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
  - diagnostic imaging screening services such as barium enema
  - surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
  - such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer

  If you are determined to be at high or increased risk, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician. Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

NOT COVERED:

- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining/maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third-party request
- services for or related to routine vision examinations for adults age 19 and older

RECONSTRUCTIVE SURGERY

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19, including dental implants • Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- If more than one (1) surgical procedure is performed by the same professional provider during the same operation, the plan covers the surgical procedures based on the allowed amount for each procedure. The plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- For hospital/facility charges, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care".

NOT COVERED:

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

SKILLED NURSING FACILITY CARE

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 50% coinsurance after deductible

NOTES:

- Coverage is limited to a maximum benefit of 120 days per person per confinement. Successive periods of hospital and skilled nursing facility confinements are considered one (1) period of confinement unless the dates of discharge and readmission are separated by at least 90 days.
- Skilled care ordered by a physician includes skilled care ordered by an optometrist, chiropractor, or advanced practice nurse when ordered within the scope of their licensure.

NOT COVERED:

- custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care
- services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care
- services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience
- treatment, services or supplies that are not medically necessary and appropriate

TRANSPLANT

The Plan Covers:	Blue Distinction Centers for Transplants℠ (BDCT) Providers	Non-Blue Distinction Centers for Transplants (BDCT) Providers
Benefits may be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of the following medically necessary and appropriate human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell and umbilical cord blood transplant procedures • Autologous bone marrow transplant and peripheral blood stem cell transplant procedures • Heart • Heart-lung • Kidney - pancreas transplant performed simultaneously (SPK) • Liver - deceased donor and living donor • Liver - kidney • Lung - single or double • Pancreas transplant - deceased donor and living donor segmental ▪ pancreas transplant alone (PTA) ▪ simultaneous pancreas - kidney transplant (SPK) ▪ pancreas transplant after kidney transplant (PAK) • Small-bowel and small-bowel/liver	You pay 20% coinsurance of the transplant payment allowance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider.	*Participating Transplant Provider:* You pay 50% coinsurance of the transplant payment allowance after deductible. *Nonparticipating Transplant Provider.* NO COVERAGE

NOTES:

- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and Blue Plus. Please verify with your provider that form 2728 has been completed and submitted.
- Kidney transplants when not done in conjunction with an eligible major transplant noted above, and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," and "Office Visit and Professional Services" etc.
- Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) providers level of benefits when the transplant services are not available at a BDCT provider.
- If you live more than 50 miles from a BDCT provider, there may be a benefit available for travel expenses directly related to a preauthorized transplant.
- If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:
  - when both the recipient and the donor are members, each is entitled to the benefits of their health care plan;
  - when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this health care plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and, 2) benefits provided to the donor will be charged against the recipient's coverage under this health care plan to the extent that

NOTES:

benefits remain and are available under this health care plan after benefits for the recipient's own expenses have been paid;

- when only the donor is a member, the donor is entitled to the benefits of this health care plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this health care plan; and, 2) no benefits will be provided to the non-member transplant recipient; and,
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's health care plan limit.

- For services not included in the transplant payment allowance, please refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
- Prior authorization is required for human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures, and should be submitted in writing or faxed to 651-662-1624.

NOT COVERED:

- transplant services you receive from a nonparticipating provider
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow transplant and peripheral stem cell support procedures that are considered investigative or not medically necessary and appropriate
- living donor organ and/or tissue transplants, except as provided herein
- benefits for travel expenses when you are using a non-BDCT provider
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this plan
- services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered

Definitions:

- BDCT provider means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.
- Participating transplant provider means a hospital or other institution that has a contract with Blue Cross and Blue Shield of Minnesota or with their local Blue Cross and/or Blue Shield plan to provide human organ, bone marrow, cord blood and peripheral stem cell transplant procedures.
- Transplant payment allowance means the amount the plan pays for covered services to a participating transplant provider for services related to human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures in the agreement with that provider.

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

GENERAL EXCLUSIONS

Except as specifically provided in this health care plan or as Blue Plus is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "Not Covered" in the Benefit Charts and as noted below:

No benefits will be provided for the following:

1. Treatment, services or supplies which are not medically necessary and appropriate based on the definition of "medically necessary and appropriate" in the "Terms You Should Know" section.
2. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
3. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
4. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by Blue Plus and deemed eligible for coverage.
5. Services rendered by other than ancillary providers, facility providers or professional providers.
6. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy, or chelation therapy that is not medically necessary and appropriate.
7. Services for any other medical or dental service or treatment or prescription drug, except as provided herein.
8. Services that are provided without charge, including services of the clergy.
9. Services rendered prior to your effective date of coverage.
10. Services incurred after the date of termination of your coverage, except as provided herein.
11. Services rendered by a provider who is a member of your immediate family.
12. Services for dependents if you have single coverage.
13. Services that are prohibited by law or regulation.
14. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran’s Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
15. Services for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under provisions of federal, state, or local government’s worker's compensation, occupational disease or similar legislation. This exclusion applies whether or not you claim the benefits or compensation.
16. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
17. Charges billed by an out-of-network provider for the completion of a claim form.
18. Services for furnishing medical records or reports and associated delivery services.
19. Services and fees for or related to health clubs and spas.
20. Services for educational classes or programs, except as required by law.
21. Services primarily educational in nature, except as provided herein.
22. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
23. Charges for the covered patient’s failure to keep a scheduled visit.
24. Fees or dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
25. Services for hippotherapy (equine movement therapy).

26. Services for or related to therapeutic acupuncture, except for medically necessary and appropriate services for the treatment of chronic pain (defined as a duration of at least six (6) months), or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy (the exceptions are limited to 20 visits per person per calendar year for all networks combined).
27. Maintenance services.
28. Services for or related to therapeutic massage.
29. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs, etc.; and all related material and products for these programs.
30. Nonprescription supplies such as alcohol, cotton balls and alcohol swabs.
31. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
32. Services that are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
33. Services provided during an e-visit for the sole purpose of: scheduling appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and, services that would similarly not be charged for in an onsite office visit.
34. Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; and, additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
35. Physical, occupational, and speech therapy Services for or related to learning disabilities and disorders, except when Medically Necessary and Appropriate and provided by an eligible health care Provider.
36. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
37. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third-party request.
38. Services for or related to gene therapy or cell therapy until they have been evaluated by Blue Plus and deemed eligible for coverage.
39. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
40. Prescription drugs, including but not limited to biological products, biosimilars, and gene or cell therapies, that have an alternative drug available similar in safety and effectiveness and is more cost-effective.
41. Services for or related to the repair of scars and blemishes on skin surfaces.
42. Services for or related to fetal tissue transplantation.

Medical and Behavioral Health Care Management

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

Prior authorization and admission notification are required.

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

Prior Authorization

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

Participating Providers in Minnesota and Bordering Counties

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

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

You are required to obtain prior authorization when you use nonparticipating providers and any provider outside of Minnesota/bordering counties. Some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed, it is found that services received from a nonparticipating provider or any provider outside Minnesota/bordering counties were not medically necessary and appropriate, you are liable for all of the charges. We prefer that all requests for prior authorization be submitted to us in writing to ensure accuracy. **Please call Customer Service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

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

Expedited review process

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

We prefer that all requests for prior authorization be submitted to us in writing to ensure accuracy. **Please call Customer Service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Admission Notifications

- **Admission notification** is a process whereby the provider, or you, informs us that you will be admitted for inpatient hospitalization or post-acute care services (e.g., long-term acute care, acute rehabilitation, skilled nursing facility, residential treatment or half-way house). We require that you, or your provider, as determined below, call us at least 72 hours prior to being admitted or as soon as reasonably possible, no later than two (2) business days, following the admission.

- **Emergency admission notification** is a process whereby the provider, or you, inform us of an unplanned or emergency admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.

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

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

Participating Providers

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

Nonparticipating Providers

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

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

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

Medical and Behavioral Health Care Management Overview

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

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 6 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Participating Provider Outside of Minnesota/Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 6 working days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 6 working days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

Choosing a Health Care Provider

You may choose any eligible provider of health services for the care you need. We may pay higher benefits if you choose in-network providers. Generally, you receive the best benefit from your health plan when you receive care from in-network providers.

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

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

In-Network Providers

When you choose in-network providers, you get the most benefits for the least expense and paperwork. In-network providers have a contract with Blue Plus specific to this plan. In-network providers are providers in the Blue Plus Southeast MN network. In-network providers are required to take care of prior authorization, admission notification, and emergency admission notification requirements (please refer to "Health Care Management") and send your claims to us. We send payment to the provider for covered services you receive.

Your provider directory lists in-network providers in our service area and may change from time to time, at least once a month, including as providers or Blue Plus initiate or terminate network contracts. **Prior to receiving services, it is recommended that you verify your provider's network status with Blue Plus, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan.** If you receive a claim for services from a provider whose status changed from in-network to out-of-network, you may notify us and we will reprocess the claim as an in-network claim (as long as the provider accepts our in-network reimbursement rates and complies with any prior authorization or information requirements), if three criteria are met: (1) the claim is for a service provided after the network status change went into effect but before the change was posted in the online directory; (2) we did not notify you of the network status change before the service was provided; and (3) we are unable to verify that the online directory displayed the correct network status on the date the service was provided. For a list of providers in the directory, visit www.bluecrossmnonline.com ("Member Log in" then "Find a Doctor") or contact Customer Service. For benefit information, please refer to "Benefit Overview" and "Benefit Chart."

Out-of-Network Providers

Out-of-Network Participating Providers

Out-of-network participating providers are providers who have a contract with us or the local Blue Cross and/or Blue Shield plan (participating providers) but are not in-network providers because the contract is not specific to this plan. Rather, this is Blue Cross' larger open access network. Out-of-network participating providers may take care of prior authorization, admission notification, and emergency admission notification requirements (please refer to "Health Care Management") and may file claims for you. Verify with your provider if these are services they will provide for you. Most out-of-state out-of-network participating providers accept our payment based on the allowed amount. We recommend that you contact the out-of-state out-of-network participating provider and verify if they accept our payment based on the allowed amount to determine if you will have additional financial liability.

Nonparticipating Providers

Nonparticipating providers have not entered into a network contract with us or the local Blue Cross and/or Blue Shield plan. You are responsible for providing prior authorization, admission notification, and emergency admission notification when necessary (please refer to "Health Care Management") and submitting claims for services you receive from nonparticipating providers. Please refer to "Liability for Health Care Expenses" for a description of charges that are your responsibility. Please note that you may incur significantly higher financial liability when you use nonparticipating providers compared to the cost of receiving care from in-network providers. If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the DIFFERENCE between what Blue Plus would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket limit.

This is in addition to any applicable deductible, copay, or coinsurance. Benefit payments are calculated on Blue Plus' allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

General Provider Payment Methods

Participating Providers

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

- Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments
  - Fee-for-Service – Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.
  - Discounted Fee-for-Service – Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.
  - Discounted Fee for Service, Withhold and Bonus Payments – Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 20%) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

In addition, as an incentive to promote high quality care and as a way to recognize those providers that participate in certain quality improvement projects, providers may be paid a bonus based on the quality of the provider's care to its members. In order to determine quality of care, certain factors are measured, such as member/patient satisfaction feedback on the provider, compliance with clinical guidelines for preventive services or specific disease management processes, immunization administration and tracking, and tobacco cessation counseling.

Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

- Institutional (i.e., hospital and other facility provider) Participating Provider Payments
  - Inpatient Care
    - Payments for each Case (case rate) – Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
    - Payments for each Day (per diem) – Providers are paid a fixed amount for each day the patient spends in the hospital or facility.
    - Percentage of Billed Charges – Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.
  - Outpatient Care
    - Payments for each Category of Services – Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
    - Payments for each Visit – Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
    - Payments for each Patient – Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

Special Incentive Payments

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

Pharmacy Payment

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

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

Nonparticipating Providers

Nonparticipating providers are not network providers. Payment for covered services provided by a nonparticipating provider will be at the out-of-network level. See "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

When you use a nonparticipating provider, benefits are substantially reduced, and you will likely incur significantly higher out-of-pocket expenses. A nonparticipating provider does not have any agreement with Blue Plus or another Blue Cross and/or Blue Shield plan. For services received from a nonparticipating provider (other than those described under "Special Circumstances" below), the allowed amount will be based upon one of the following payment options to be determined at Blue Plus' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Plus may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge or Medicare Advantage allowed charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Plus. The allowed amount for a nonparticipating provider is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the nonparticipating provider's billed charges. You will be paid the benefit under the plan and you are responsible for paying the nonparticipating provider. The only exception to this is stated in "General Information," "Whom We Pay." The amount you pay does not apply toward any out-of-pocket limit contained in the plan.

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

- ***Example***

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

	Participating Provider	Nonparticipating Provider
Provider Charge:	$150	$150
Allowed Amount:	$100	$80
Blue Plus Pays:	80% ($80)	60% ($48)
Coinsurance You Owe:	20% ($20)	40% ($32)
Difference Up to Billed Charge You Owe:	None	$70 ($150 minus $80)
You Pay:	$20	$102

Special Circumstances

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

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

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

Women's Health and Cancer Rights Act

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

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

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

Coverage of Health Care Services on the Basis of Gender

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

Inter-Plan Arrangements

Out-of-Area Services

Blue Plus has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain health care services outside of Blue Plus service area, the claim for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of Blue Plus' service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("host Blue"). Some providers ("nonparticipating providers") do not contract with the host Blue. Blue Plus explains below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care benefits (except when paid as medical claims/benefits) and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Blue Plus to provide the specific service or services.

BlueCard® Program

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

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

- the billed charges for covered services; or,
- the negotiated price that the host Blue makes available to Blue Plus.

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

Estimated pricing and average pricing, going forward, 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 Blue Cross uses for your claim because they will not be applied retroactively to claims already paid.

Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

Nonparticipating Providers Outside Blue Plus' Service Area

When covered health care services are provided outside of Blue Plus' 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 for the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment Blue Plus will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Blue Cross Blue Shield Global® Core

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

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Out-of-Country Benefits

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

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

Eligible services will be processed at the out-of-network level of benefits.

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

Recommendations by Health Care Providers

Referrals are not required. Your provider may suggest that you receive treatment from a specific provider or receive a specific treatment. Even though your provider may recommend or provide written authorization for a referral for certain services, the provider may be an out-of-network provider or the recommended services may be covered at a lesser level of benefits or be specifically excluded. When these services are referred or recommended, a written authorization from your provider does not override any specific network requirements; notification requirements; or, plan benefits, limitations or exclusions.

Services that are Investigative or not Medically Necessary and Appropriate

Services or supplies that are investigative or not medically necessary and appropriate are not covered. No payment of benefits will be allowed under this plan including payments for services you have already received. The terms "investigative" and "medically necessary and appropriate" are defined in "Terms You Should Know."

Continuity of Care

Continuity of Care for Current Members

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

Continuation for up to 120 days if you:

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

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

Transition to Network Providers

Blue Plus will assist you in making the transition from an out-of-network to an in-network provider if you request us to do so. Please contact Customer Service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of care applies only if your provider agrees to: 1) accept Blue Plus' allowed amount; 2) adhere to all Blue Plus prior authorization requirements; and, 3) provide Blue Plus with necessary medical information related to your care.

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

Termination by Provider

If your provider terminates its contract with Blue Plus, we will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Provider Termination for Cause

If we have terminated our relationship with your provider for cause, we will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Cost-Sharing Disclosure

The amount of the flat fee copay is calculated on provider billed charges. The provider's billed charge is the full amount that the provider bills and does not include any discount that we negotiate with the providers.

The coinsurance percentage is calculated on the allowed amount. The allowed amount is the negotiated amount of payment that participating providers have agreed to accept as full payment for a covered service at the time your claim is processed. For any nonparticipating provider, the allowed amount is (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by another Blue Cross or Blue Shield plan or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Plus may result in an allowed amount that is a lower amount than if calculated by another payment option. If you have a deductible, your deductible amount is subtracted from the allowed amount, then the coinsurance is calculated based on the remainder.

Minnesota Life and Health Insurance Guaranty Association Notice

Notice Concerning Policyholder Rights in an Insolvency under Minnesota Life and Health Insurance Guaranty Association Law

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, subject to limits and exclusions, in the event the

insurer becomes financially impaired or insolvent. The protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear lake, Minnesota 55110
Telephone: (651) 407-3149
Fax: (651) 407-3150
Executive Director: Gerald C. Backhaus

The **maximum amount** the Guaranty Association will pay for all policies on one life by the same insurer **is limited to $500,000. Subject to this $500,000 limit**, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 or the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the Association shall not be responsible for more than $10,000,000 in claims for all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits, you may still recover a part, or all, of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

The coverage provided by the Guaranty Association is not a substitute for using care in selecting insurance companies that are well managed and financially stable. In selecting an insurance company or policy you are advised not to rely on coverage by the Guaranty Association.

This notice is required by Minnesota state law to advise policyholders of life, annuity or health insurance policies of their rights in the event their insurance carrier becomes financially impaired or insolvent. This notice in no way implies that the company currently has any type of financial problems. All life, annuity and health insurance policies are required to provide this notice.

Important Notice From Blue Plus About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Plus and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug plan or join a Medicare Advantage plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of**

coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **Blue Plus has determined that the prescription drug coverage offered by your plan is, on average for all members, expected to pay out as much as standard Medicare prescription drug coverage pays, and is therefore considered Creditable Coverage. Because your existing coverage is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2)-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Blue Plus coverage will not be affected. You may keep your current Blue Plus coverage and this plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Blue Plus prescription drug coverage, be aware that you and your dependents might not be able to get this coverage back, depending on your employer's eligibility policy. This risk might also extend to your medical coverage, so it is worthwhile to ask before enrolling in a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Blue Plus and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact Customer Service using the telephone number provided in the "Customer Service" section.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Blue Plus changes. You may request a copy of this notice any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**, TTY users call **1-877-486-2048**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

GENERAL INFORMATION

Entire Contract

This contract, the application for coverage, identification issued, and any amendments make up the entire contract of coverage. The contractholder hereby expressly acknowledges his/her understanding that this contract constitutes a contract solely between the contractholder and Blue Plus. Please refer to "Independent Corporation" in the front of this contract.

This contract is issued and delivered in the state of Minnesota, it is subject to the substantive laws of the state of Minnesota, without regard for its choice of law principles; and it is not subject to the substantive laws of any other state. Blue Plus does not issue individual coverage, such as this contract, through any arrangement with an employer. Blue Plus is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

Time Periods

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

Time Limit for Misstatements

We issue this benefit booklet based on the statements you made on your application. If your application contained misstatements or falsifications that affected our approval of your application, we may rescind the coverage, deny payment of claims, or ask you to sign a rider to continue the coverage. If you misstate your age on your application, we will refund overpayments or collect the balance due on the premium for your correct age. We will provide at least 30 days advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the health plan may be terminated retroactively. After your coverage is in force for two (2) years, no statements made on your application, except those made in fraud, are used to void your benefit booklet or to deny a claim for care that starts after the end of the two (2) year period.

Changes to the Contract

All changes to the contract must be approved by us. No agent can legally change the contract or waive any of its terms.

Legal Actions

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

Grace Period

If you *are* receiving advance payments of the premium tax credit: After your first premium payment, we allow a 3-month grace period for payment. The first grace period month starts on the day after the initial due date for the payment period. You are covered during this grace period provided your premium is paid in full by the end of the 3-month grace period. Blue Plus may pend (that is, not immediately pay) claims for services you receive during the second and third months of the grace period. In addition, you may be required to pay for prescriptions you pick up from a pharmacy during the second and third months of the grace period.

If we do not receive payment by the end of the 3-month grace period, your health care plan lapses retroactively to the last day of the first month of the grace period. You are responsible for any claims incurred during the second and third months of the grace period.

In the event your coverage is terminated for nonpayment, you may not be able to obtain new individual health insurance coverage again until the next annual enrollment period unless you experience a qualifying event.

If you are *not* receiving advance payments of the premium tax credit: After your first premium payment, we allow a 31-day grace period for payment. The grace period starts on the day after the initial due date for the payment period. You are covered during this grace period provided your premium is paid in full by the end of the grace period. If we do not receive payment by the end of the grace period, your health care plan lapses retroactively to the date to which coverage has been paid.

In the event your coverage is terminated for nonpayment, you may not be able to obtain new individual health insurance coverage again until the next annual enrollment period unless you experience a qualifying event.

If you apply for reinstatement and we approve your application, then your policy would be reinstated upon approval, or lacking such approval, upon the forty-fifth (45th) day following the date we conditionally received your premium payment, unless we have otherwise notified you in writing that your application was not approved. Any reinstated policy will only take effect as of the date of reinstatement, and claims incurred prior to that date are not eligible for coverage. Otherwise, the same terms and conditions apply as applied under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. We may apply any premium accepted in connection with a reinstatement to a period for which premium has not been previously paid.

Third-Party Payments of Premium and/or Cost-Sharing

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

1. the Ryan White HIV/AIDS Program;
2. other Federal and State government programs (or grantees) that provide premium and cost-sharing support for specific individuals;
3. Indian tribes, tribal organizations, and urban Indian organizations;
4. small employers that qualify as a Qualified Employer Heath Reimbursement Arrangement (QSEHRA) under the 21st Century Cures Act; and,
5. employers using a Health Reimbursement Arrangement (HRA) are permitted, to the extent such payments are lawfully funded through an HRA that constitutes a group health plan under applicable regulations, which have not been enjoined by a court of competent jurisdiction. This is known as an Individual Coverage Health Reimbursement Arrangement (ICHRA).

Blue Plus may, in its sole discretion and in accordance with applicable law and regulatory guidance, decline to accept premium and cost-sharing payments made directly or indirectly* by any other person or entity from which Blue Plus is not required by law to accept third-party premium and/or cost-sharing payments.

"Payments" include those made by any means, for example:

- cash,
- check,
- money order,
- credit card payment, or
- electronic fund transfer, etc.

Third parties not listed above (or from whom Blue Plus is not required by law to accept third-party payment) are referred to as "ineligible third-parties."

For purposes of clarity, but not limitation, commercial (or for-profit) entities, hospitals, and other health care providers (including, without limitation, suppliers) are ineligible third-parties. Religious institutions and other not-for-profit organizations may also be considered ineligible third-parties.

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

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

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

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

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

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

Whom We Pay

When you use an in-network provider for covered services, we pay the provider. When you use a nonparticipating provider for covered services, we pay you. You may not assign your benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may ask us to pay a nonparticipating provider for covered services for a child. When we pay the provider at the request of the custodial parent, we have met our obligation under the plan. This provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and, certain out-of-state institutional and medical/surgical providers.

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

Good Faith Estimate of Service Costs

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

Fraudulent Practices

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

Payments Made in Error

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

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

Liability for Health Care Expenses

Blue Plus, AllianceRx Walgreens Prime and Fairview Specialty Pharmacy welcome the use of drug manufacturer coupons to help pay the cost of specialty drugs. However, only the amount you pay out-of-pocket for your specialty drug will apply to your coinsurance, copay, or deductible cost-sharing responsibilities or out-of-pocket limit. The dollar amount of any coupon provided to you by providers or manufacturers will not count towards coinsurance, copays, or deductible cost-sharing responsibilities or out-of-pocket limit.

This ensures that you receive credit for what you have actually paid out-of-pocket, not the amount a manufacturer has contributed toward your specialty drug purchase.

Charges That Are Your Responsibility

In-Network Providers

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

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

Out-of-Network Providers

Out of Network Participating Providers

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

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

Nonparticipating Providers

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

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

Medical Policy Committee and Medical Policies

Blue Plus applies medical policies in order to determine benefits consistently for its members. Internally developed policies are subject to approval by our Medical Policy Committee, which consists of independent community physicians who represent a variety of medical specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, Blue Plus' goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time to time, new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with Blue Plus' policies in effect at the time treatment is rendered or, if applicable, prior authorization may be required. Internally developed medical policies can be found at www.bluecrossmnonline.com (click on "For Providers" at the bottom of the page, then "Medical Policy" under "Tools and Resources"). All medical policies are available upon request.

Eligibility

Eligible Dependents

1. Legally married spouse.
2. Natural-born dependent children and/or stepchildren to the dependent child age limit specified in "Benefit Overview."
3. Legally adopted children and children placed with you or your covered spouse for adoption to the dependent child age limit specified in "Benefit Overview." 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. Dependent children for whom you or your spouse have been appointed legal guardian to the dependent child age limit specified in "Benefit Overview."
5. Foster children placed with you or your spouse by an authorized placement agency or by judgement decree, or other order of any court of competent jurisdiction.
6. Grandchildren who both live with you or your covered spouse continuously from birth and are financially dependent upon you or your covered spouse to the dependent child age limit specified in "Benefit Overview."

7. Otherwise eligible children of the contractholder who are required to be covered by reason of a Qualified Medical Child Support Order to the dependent child age limit specified in "Benefit Overview."
8. Disabled dependent children after reaching the dependent child age limit specified in "Benefit Overview" while covered under this plan if all of the following apply:
   a. primarily dependent upon you; and,
   b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness or mental disorders; 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, we may request proof again two (2) years later, and each year thereafter; and,
   d. must have become disabled prior to reaching the limiting age.
9. A domestic partner of the unmarried contractholder. A domestic partner:
   a. is in a committed and mutually exclusive relationship, jointly responsible for the domestic partner's welfare and financial obligations; and
   b. is at least 18 years of age and unmarried; and
   c. resides with the domestic partner in the same principal residence and intends to do so permanently; and
   d. is not a blood relative of the domestic partner; and
   e. is mentally competent.
10. Children of the domestic partner of the contractholder to the dependent child age limit specified in "Benefit Overview."

Effective Date of Coverage

Coverage starts on the date specified in "Benefit Overview." This is the effective date for the contractholder and any dependents enrolled before that date.

Adding New Dependents

Monthly premiums must be paid from the date coverage starts. Dependents may be added during the Initial open enrollment period and subsequent annual open enrollment periods, and in the special enrollment situations outlined below. This section outlines the time periods for application and the date coverage starts.

NOTE: New dependents may not be added to dependent child-only coverage.

Special Enrollment Periods

Special enrollment periods are defined as a period during which you and your family have a right to sign up for new or make changes to an existing health coverage**.** Special enrollment qualifying life events include, but are not limited to, certain permanent moves, certain changes in your income and changes in your family size (such as if you marry, birth or adoption) or a loss of coverage. If you are enrolled in a plan that counts as minimum essential coverage in most instances consumers have 60 days from the occurrence of the qualifying life event to sign up for or make changes to existing coverage; however there are some instances defined in the chart below that allow 60 days before and after a qualifying life event to sign up for or make changes to existing coverage.

All special enrollment information is determined by MNsure. If you'd like to request a change to your current MNsure coverage, you must contact MNsure directly.

Qualifying Life Event
Loss of pregnancy related or medically needy coverage under Medicaid. Loss of Minimum Essential Coverage (MEC) (includes but not limited to): • Loss of eligibility for employer sponsored coverage due to job loss or reduction in hours • Employer no longer offers benefits or closes • Legal separation/Divorce from policy holder • Employee/policy holder becomes Medicare entitled • Death of policy holder • Child loses dependent status • Loss of eligibility for Medicaid, MinnesotaCare or CHIP • Expiration of COBRA or non-calendar year policy

Qualifying Life Event
• Moving out of existing ACO or HMO plan service area
A permanent move to a new area that offers different health plan options. You must have had minimum essential coverage (MEC) for 1 or more days during the 60 days preceding the permanent move; unless you have an eligible exception. Documentation confirming move and prior MEC are required.
Marriage. You or your spouse must have had minimum essential coverage (MEC) for 1 or more days during the 60 days preceding the date of marriage; unless you have an eligible exception.
• Birth • Adoption • Placed for Adoption • Placed in Foster Care • Court Order • Release from incarceration
A change in income, household or other status that affects eligibility for Advance Premium Tax Credit (APTC)* or Cost-sharing Reductions (CSR). Must currently be enrolled in a Qualified Health Plan or have had medical essential coverage within the prior 60 days. *APTC is only available through MNsure
Determined to be newly eligible for Advanced Premium Tax Credit (APTC)* due to not being eligible for coverage by an eligible employer sponsored plan *APTC is only available through MNsure
• MNsure determined that an unintentional enrollment error is the result of an action or omission by an agent of MNsure or Non-Exchange Entity. • MNsure determines that there has been a violation of a material provision of the health plan in which you or a dependent are enrolled. Must currently be enrolled in a Qualified Health Plan.
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
Individual Coverage Health Reimbursement Arrangement (ICHRA)
An individual demonstrates to the Minnesota Insurance Marketplace that he/she meets other exceptional circumstances as the Minnesota Insurance Marketplace may provide.
An individual who was not previously a citizen, national or lawfully present individual gains such status.
An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one (1) time per month.
In the event the subscriber or dependent is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in Minimum Essential Coverage (MEC) and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. The dependent of a victim of domestic abuse or spousal abandonment applying for or covered on the same application as the victim, also may enroll in coverage at the same time as the victim.

Renewal of This Contract

We renew this contract on the first day of the month specified in "Benefit Overview," which is the first day of the policy year. This contract is guaranteed renewable at a rate that does not take into account the individual claims experience or any change in the health status of any covered person that occurred after the initial issuance of coverage for that person under this contract and can only be canceled as specified in the section titled "Cancellation of This Contract." You accept our renewal by paying monthly premiums when due. Rates are changed on an annual basis only and will remain the same for one (1) year unless the number of dependents covered under your contract changes.

Cancellation of This Contract

We have the right to cancel, decline to issue, or fail to renew this contract, including retroactively, if required premiums are not paid when due, if you perform an act that constitutes fraud or intentional misrepresentation of a material fact. We will give you 30 days advance notice before the retroactive termination (retroactive termination is also called "rescission").

We have the right to cancel this contract if you move out of the plan's network service area. We will give you 90 days advance notice before the cancellation.

We have the right to cancel this contract if you fail to complete and return information requested by Blue Plus in connection with confirming your eligibility.

We may also cancel this contract if we cease doing business in the individual health plan market. We will give you 180 days advance notice before the cancellation.

If we cancel this contract, coverage will be cancelled for the contractholder and all covered dependents.

You may cancel this contract or coverage for any dependent at any time by giving us advance signed written notice.

In the event a specific cancellation date is provided, coverage will be terminated per the following:

- requested cancellation date is prior to the date the notice was received by Blue Plus, the termination date will be the first of the following month in which Blue Plus received the notice;
- requested cancellation date precedes the date the notice was received by Blue Plus and is not the first of the month, the termination date will be the first of the following month from the requested date; or,
- requested cancellation date precedes the date the notice was received by Blue Plus and is the first of the month, the termination date will be the requested date.

We refund any unearned premiums in the event of cancellation of this contract.

Continuation of Coverage

Coverage for dependents ends on the date the contractholder's coverage ends or the date when the dependent is no longer eligible for coverage. Dependents may continue coverage under this health care plan if coverage ends because of any of the qualifying events listed below. In all cases, continuation ends in the event this health care plan is canceled as specified in the section titled "Cancellation of This Contract."

Qualifying Event	Who May Continue	Maximum Continuation Period
Divorce or legal separation	Ex-spouse/spouse and any dependent children that lose coverage	Date coverage would otherwise end.
Death of contractholder	Surviving spouse and dependent children	Earlier of: 1. Enrollment Date in other group coverage, or 2. Date coverage would otherwise end if the contractholder had lived.
Dependents lose eligibility due to the contractholder's enrollment in Medicare	Ex-spouse/spouse who was covered on the day before the entry of a valid decree of dissolution of marriage and any dependent children that lose coverage	Earliest of: 1. 36 months, 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment Date in other group coverage, or 3. Date coverage would otherwise end.
Contractholder only cancels coverage	All dependents	Date coverage would otherwise end.

Choosing Continuation

Your dependent must notify us in writing to continue coverage. We require your dependent to pay the first continuation premiums at the time of notice, except that surviving dependents of a deceased subscriber have 90 days to pay the first continuation premiums. After this initial grace period, everyone must pay premiums monthly in advance to us to maintain coverage in force.

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

We must notify the contractholder or eligible dependent of the option to continue coverage within 10 days of receiving notice of a qualifying event. The contractholder or dependent must notify us within 60 days of a qualifying event, such as divorce or legal separation that would result in a loss of coverage for the dependent.

Second Qualifying Event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to an extended continuation period. The dependent must pay continuation premiums in the same manner as for the initial qualifying event. Refer to the preceding chart to determine the length of the extended continuation period.

Coordination of Benefits

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

Definitions

These definitions apply only to this section.

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

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

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

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

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

2. "This plan" means this individual health care plan that provides health care benefits.

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

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

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

4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs.

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

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

Order of Benefits Rules

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

   a. the other plan has rules coordinating its benefits with this plan's benefits; and,
   b. the other plan's rules and this plan's rules, in part 2. below, require this plan to determine benefits before the other plan.

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

   a. Nondependent/dependent. The plan that covers the person as a group member (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

   b. Dependent child of parents not separated or divorced or not separated through termination of a domestic partner relationship. When this plan and another plan cover the same child as a dependent of different persons, called "parents":

      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

   c. Dependent child of parents divorced or separated. If two (2) or more plans cover a child dependent of divorced or separated parents, we determine benefits in this order:

      1) first, the plan of the parent with physical custody of the child;
      2) then, the plan that covers the spouse of the parent with physical custody of the child;
      3) finally, the plan that covers the parent not having physical custody of the child.

      However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

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

   e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the plan that has covered a group member longer determines benefits before the plan that has covered that person for the shorter time.

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

Effect on Benefits of This Health Care Plan

When this section applies:

1. When the Order of Benefits Rules require this health care plan to be a secondary plan, this part applies. Benefits of this health care plan may be reduced.

2. Reduction in this plan's benefits may occur under circumstances such as the following:

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

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. We have the right to decide which facts are needed. We may get needed facts from, or give them to, any other organization or person. We do not need to tell or get the consent of any person to do this, unless applicable federal or state law prevents disclosure of information without the consent of the patient or patient's representative. Each person claiming benefits under this plan must give us any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If this happens, we may pay that amount to the organization that made that payment. That amount will then be considered 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If we pay more than we should have paid under these coordination of benefit rules, we may recover the excess from any of the following:

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

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

Reimbursement and Subrogation

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

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

Notice Requirement

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

Duty to Cooperate

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

Release of Records

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

By enrolling in a product that features certain designated providers, you agree to allow Blue Plus to share certain information with such designated providers. Such information may include your name, address and telephone number, as well as your past, current and future health and account records about services you have received from such designated providers and other care providers unrelated to such designated providers. These records may be used by the designated providers as needed to manage or coordinate your care and to improve the quality of that care.

FILING A CLAIM AND REVIEW PROCEDURE

In-network providers file your claims for you. If you use an out-of-network provider, however, you may have to file the claim yourself. If you notify us of a claim we will send you a claim form within 15 days. If we fail to send you a claim form within 15 days, your claim will be treated as if you had submitted all required proof of loss documentation. Claim forms are also available by calling the Customer Service telephone number listed in the front of the benefit booklet and on our website at www.bluecrossmnonline.com. You can also write us at the address listed in the front of the benefit booklet. You must file a written claim within 90 days after a covered service is provided. If this is not reasonably possible, we accept claims for up to 12 months after the date of service. Normally, failure to file a claim within the required time limits will result in denial of your claim. We waive these limits, however, if you cannot file the claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

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

Payment of a claim does not preclude the right of Blue Plus to deny future claims or take any action it determines appropriate, including seeking repayment of claims already paid. Blue Plus may also seek rescission of the contract in instances of fraud and intentional misrepresentation.

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

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

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

Standard Exception Requests

We will review standard requests and notify the enrollee or his/her designee and the prescribing health care provider of our determination within 72 hours of receiving the request. We will promptly grant an exception if criteria is met.

Expedited Exception Requests Based on Exigent Circumstances

Expedited requests may be made when "exigent circumstances" exist. "Exigent circumstances" may exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a drug not on the covered drug list. We will review requests that meet the criteria for expedited review and notify the enrollee or his/her designee and the prescribing health care provider of our determination within 24 hours of receiving the request.

External Review of a Standard or Expedited Exception Request

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

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

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

APPEAL PROCESS

Introduction

It is the responsibility for MNsure and Blue Plus to respond to appeals. If you are appealing an eligibility decision for either eligibility to purchase through MNsure or related to subsidies available through MNsure, you must contact MNsure through the following methods:

- Visit www.mnsure.org and log into your account
- Call the contact center toll-free at 1-855-366-7873
- Mail the appeal request form to: MNsure, 81 East 7th Street, Suite 300, St. Paul, MN 55101-2211
- In person at the Minnesota Department of Human Services Information Desk: 444 Lafayette Road N., St. Paul, MN 55101

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

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

In addition, you may file your appeal with the Minnesota Commissioner of Health at any time by calling (651) 201-5100 or toll-free 1-800-657-3916.

Definitions

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

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

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

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

First Level Appeals That Do Not Require a Medical Determination

First Level Oral Complaint

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

First Level Written Appeals

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

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

we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension. You have the right to review the information that we relied on in the course of the appeal.

First Level Appeals that Require a Medical Determination

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

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

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

Definitions

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

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

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

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

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

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

Standard First Level Appeal

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

Expedited First Level Appeal

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

Second Level Appeals to Blue Plus Internal Appeals Committee

If our final decision on your first level appeal is wholly or partially adverse to you, you may appeal our final decision through External Review, as described below. Alternatively, you may voluntarily appeal to our internal appeals committee (second level appeal), as described in this section, before seeking External Review.

If you appeal to our internal appeals committee, you may either have the appeal decided solely on the written submissions or you may request a hearing in addition to your written submissions. You may receive continued coverage pending the outcome of the appeals process. You may request a form that on which you can include all the information necessary for your appeal. During the course of our review, we will provide you with any new evidence

that we consider or rely upon, as well as any new rationale for a decision. If our decision is wholly or partially adverse to you, the notice will advise you of how to submit the decision to External Review as described below. If you request, we will provide you a complete summary of the appeal decision.

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

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

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

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

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

External Review

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

If your appeal concerns a complaint decision relative to a health care service or claim and you believe Blue Plus' appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf may submit the appeal to external review. You must request External Review within six (6) months from the date of the adverse determination. External review of your appeal will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Health along with a $25 filing fee. No enrollee may be subject to filing fees totaling more than $75 per policy year. The Commissioner may waive the fee in cases of financial hardship. Blue Plus will refund the fee if our determination is reversed by the external reviewer.

Minnesota Department of Health
Attention: Managed Care Systems Section
PO Box 64975
St. Paul, MN 55101-2198

The external review entity will notify you and Blue Plus that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and Blue Plus must provide the external review entity any information to be considered.

Both you and Blue Plus will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, Blue Plus, and the Commissioner within 45 days of receiving the request for external review. The external review entity's decision is binding on Blue Plus, but not binding on you.

Expedited External Review

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

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

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

TERMS YOU SHOULD KNOW

Please refer to the "Benefit Overview" and "Benefit Charts" for specific benefits and payment information.

90dayRx - Participating 90dayRx retail pharmacies and mail service pharmacy used for the dispensing of a 93-day supply of long-term prescription drug refills.

Accountable Care Organization (ACO) - A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

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

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

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

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as provided in the "Benefit Chart." For participating providers, the allowed amount is the negotiated amount of payment that the participating provider has agreed to accept as full payment for a covered service at the time your claim is processed. We periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at participating providers as a result of expected settlements or other factors. The negotiated amount of payment with participating providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, rebates, prospective payments or other methods, we may adjust the amount due to participating providers without reprocessing individual claims. These annual or other global adjustments will not or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to us, and the percentage of the allowed amount paid by us is lower than the stated percentage for the covered service. If the payment to the provider is increased, we pay that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The Allowed Amount for All Nonparticipating Providers

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

The Allowed Amount for Nonparticipating Providers In Minnesota

For nonparticipating provider services within Minnesota, except those described under special circumstances below, the allowed amount will be an amount based upon one of the following payment options to be determined at Blue Plus' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar service; (3) a percentage of billed charges; or, (4) pricing based upon a nationwide provider reimbursement database.

The payment option selected by Blue Plus may result in an allowed amount that is a lower amount then if calculated by another payment option. When the Medicare allowed charge or Medicare Advantage allowed charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Plus.

The Allowed Amount for Nonparticipating Provider Services Outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described under special circumstances below, the allowed amount will be based upon one of the following payment options to be determined at Blue Plus' discretion: (1) a percentage, not less than 100%, of the Medicare allowed charges for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage allowed charge for the same or similar

service; (3) a percentage of billed charges; (4) pricing determined by the host Blue plan; or, (5) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Plus may result in an allowed amount that is a lower amount then if calculated by another payment option. When the Medicare allowed charge or Medicare Advantage allowed charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Plus.

Special Circumstances

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

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

Annual Open Enrollment - The period each year when individuals may enroll for coverage without a special enrollment triggering event. The annual open enrollment period generally begins prior to January each year and runs for a specified period of time. Coverage effective dates are no earlier than the first day of the next year (or later) depending on when enrollment is completed. Annual open enrollment period dates are determined by the United States Department of Health and Human Services.

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

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

Assisted Reproductive Technology (ART) - Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine, or artificial insemination), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.

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

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

Behavioral Health Therapy - A method of treating mental and substance use disorders that involves verbal and nonverbal communication about thoughts, feelings, emotions, and behaviors in individual, group or family sessions in order to change unhealthy patterns of coping, relieve emotional distress, and encourage improved interpersonal relations.

Benefit Chart - The schedule that lists benefits and covered services.

Benefit Overview - The section of this benefit booklet which lists items such as deductible amounts, and out-of-pocket limits, etc.

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

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

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use participating providers of a host Blue and show your membership ID to secure BlueCard Program access.

BlueCard Traditional Provider - Providers who have entered into a service agreement which designates them as a BlueCard Traditional provider with the local Blue Cross and/or Blue Shield plan outside the state of Minnesota.

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

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

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

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

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

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

Claims Administrator - Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus).

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

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

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

Coinsurance Example

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

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

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

Compound Drug - A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solutions are added. The compound drug must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.

Comprehensive Pain Management Program - A multidisciplinary program including, at a minimum, the following components:

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

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

Cosmetic Services - Surgery and other cosmetic health services which are chiefly intended to improve appearance and are not medically necessary and appropriate as determined by us.

Covered Drug List - Your designated covered drug list is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The list was developed by the Blue Plus Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. For a list of drugs on your covered drug list visit www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service.

Covered Services - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

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

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

Deductible - The amount you must pay toward the allowed amount for certain covered services each year before we begin to pay benefits. The deductibles for each person and family are specified in "Benefit Overview."

Your coinsurance and deductible amount will be based on the negotiated payment amount Blue Plus has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides.

Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements Blue Plus may receive from other parties. The dollar amount reimbursed or paid by a coupon will not count toward your deductible.

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

Drug Therapy Supply - A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.

Durable Medical Equipment - Medically necessary and appropriate equipment that we determine is prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury; and,
4. determined to be reasonable and necessary; and,
5. represents the most cost-effective alternative.

Emergency Hold - A process defined in Minnesota law that allows a provider to place a person, who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance use disorder issues.

Essential Health Benefits - Most benefits covered under this plan are essential health benefits defined by the Affordable Care Act. Benefits that are not essential health benefits are noted in the "Benefit Chart" section.

E-visit - A patient initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.

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

Family Therapy - Behavioral health therapy intended to treat an individual, diagnosed with a behavioral health condition, within the context of family relationships.

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

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

General Physician - A medical practitioner who treats acute and chronic illnesses and provides preventive care and health education to patients.

Generic Drug - A prescription drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by Blue Plus.

Group Home - A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.

Group Therapy - Behavioral health therapy conducted with multiple patients.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House - Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health Care Professional - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, occupational and speech therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services, and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Home Health Agency - A Medicare-approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24 hour-a-day professional registered nursing (R.N.) services.

Host Blue - A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with providers in its designated service area that require such providers to provide services to members of other Blue Cross and/or Blue Shield organizations.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, or condition involving a physical disorder.

In-Network Provider - In Minnesota, a provider that has entered into a specific network contract with us for this plan.

Infertility Testing - Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.

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

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

Intrauterine Insemination (IUI) - A specific method of artificial insemination in which semen is introduced directly into the uterus.

Investigative - A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We base our decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (phase I clinical trials determine the safe dosages of medication for phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients);
3. medically reasonable conclusions establishing its safety, effectiveness or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.

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

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

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

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

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

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

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

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

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

Mental Health Care Professional - A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders, substance use disorder, or addiction.

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

Mobile Crisis Services - Face-to-face, short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.

Neuropsychological Examinations - Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.

Nonparticipating Provider - Providers who have not entered into a network contract with us or the local Blue Cross and/or Blue Shield plan.

Opioid Treatment - Treatment that uses medication assisted treatment (MAT) to control withdrawal symptoms of opioid addiction.

Out-of-Network Provider - A provider with a Blue Plus and/or Blue Cross contract that is not in-network for this plan (which may also be referred to as an out-of-network participating provider) and nonparticipating providers.

Out-of-Pocket Limit - The most each person must pay each year toward the allowed amount for essential health benefits from in-network providers for covered services. After a person reaches the out-of-pocket limit, we pay 100% of the allowed amount for covered services for that person for the rest of the calendar year. Out-of-network services and non-essential health benefits do not accumulate toward the out-of-pocket limit. The dollar amount reimbursed or paid by a coupon will not count toward your out-of-pocket limit.

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

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

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

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

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

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

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

Place of Service - Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers. Providers use different types of claim forms to bill for services based on the "place of service." Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.

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

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

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

Qualifying Creditable Coverage - Health coverage provided through an individual policy; a self-funded or fully-insured group health plan offered by a public or private employer; Medicare; MinnesotaCare; Medical Assistance (Medicaid); General Assistance Medical Care; TRICARE; the Minnesota Comprehensive Health Association (MCHA); Federal Employees Health Benefit plan (FEHBP); Medical Care Program of the Indian Health Service or a tribal organization; a state health benefit risk pool; a Peace Corp health plan; Minnesota Employee Insurance Program (MEIP); Public Employee Insurance Program (PEIP); any plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; the Children's Health Insurance Program (CHIP); or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioners of Commerce or Health.

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

Rescission - A cancellation or discontinuation of coverage under the health plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage if the cancellation or discontinuance is effective retroactively to the extent it is attributable to failure to timely pay required premiums or contributions to the cost of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. Specialty drugs include, but are not limited to, drugs used for: growth hormone treatment; multiple sclerosis; rheumatoid arthritis; hepatitis C; and, hemophilia. A current list of designated specialty drugs and suppliers is available at www.bluecrossmn.com/basicrxindividualsmallgroup2021 or contact Customer Service.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with Blue Plus pertaining to the payments and exclusive dispensing of selected specialty drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, medications in specific categories or drug classes. If your physician prescribes one of these medications, there must be documented evidence that you have tried another eligible medication(s) that is safe, more clinically effective, and in some cases more cost effective before the medication subject to step therapy will be paid under the drug benefit.

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

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

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

Supplies do not include such things as:

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

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

Telemedicine Services - Telemedicine services may also be referred to as televideo consultations or telehealth services. These services provide real-time interaction between a distant site physician/medical practitioner and the member both of whom are not in the same location, but are actively communicating through interactive audio and video channels.

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

Therapeutic Camps - A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.

Therapeutic Day Care (Pre-School) - A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreation therapy, socialization therapy and independent living skills therapy.

Therapeutic Support of Foster Care - Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child's improved functioning.

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

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

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

The Blue Cross® and Blue Shield® Association is an association of independent Blue Cross and/or Blue Shield plans.

You are hereby notified, your health care benefit program is between the Subscriber and Blue Plus. Blue Plus is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and/or Blue Shield companies, permitting Blue Plus to use Service Marks in the state of Minnesota, and that Blue Plus is not contracting as the agent of the Association.

Blue Cross and Blue Shield of Minnesota
and Blue Plus

PO Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000

NOTICE OF OUR FINANCIAL INFORMATION
PRIVACY POLICIES AND PRACTICES

We are dedicated to protecting the privacy of your nonpublic personal financial information, which we collect and maintain. Nonpublic personal financial information is information we have gathered that identifies you. This notice briefly outlines what information we collect, how we protect it and how we may disclose it. We will provide notice to you of relevant changes in our practices.

Information we collect and maintain

We collect nonpublic personal financial information about you such as your name, address, and bank information if you have Pay-it-Easy from sources such as:

- Applications or other forms you submit to us
- Providers or other insurance companies
- Others in the process of administering benefits.

How we protect information

We do not disclose nonpublic personal financial information about our customers or former customers except as permitted by law. We maintain physical, electronic, and procedural safeguards that comply with legal requirements to guard your nonpublic personal financial information.

Information we may disclose

We may disclose any of the nonpublic personal financial information we collect, at different times. You can be assured that we disclose only the information that we believe is needed for a specific purpose.

Companies to whom we may disclose information

We may disclose your nonpublic personal financial information to our affiliates and to nonaffiliated third parties as permitted or required by law, such as the following types of businesses:

- Insurers and other businesses involved in the sale or servicing of insurance products, such as life insurers, insurance agents and brokers
- Health care providers
- Government regulatory agencies
- Companies that perform services on our behalf.

What organizations are covered by this notice?

This notice applies to information collected and maintained about customers of the following companies:

- Blue Cross Blue Shield of Minnesota
- Blue Plus

Questions

If you have any questions, please contact Customer Service at the number on the back of your member ID card. For a copy of our Notice of Privacy Practices, visit the Blue Cross Blue Shield of Minnesota website at bluecrossmn.com or call the number listed on the back of your member ID card.

F7303R06 (03/19)

bluecrossmn.com

NOTICE OF PRIVACY PRACTICES

Effective August 13, 2019

BlueCross BlueShield Minnesota

FOR YOUR PROTECTION

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

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

HOW BLUE CROSS SAFEGUARDS YOUR PROTECTED HEALTH INFORMATION

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

PERMITTED HANDLING OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

ADDITIONAL USES AND DISCLOSURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

YOUR AUTHORIZATION

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

YOUR RIGHTS

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

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

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

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

What is a designated record set?

It's a group of records used to administer your health benefits, including:

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

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

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

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

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

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

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

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

FUTURE CHANGES

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

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

QUESTIONS & ANSWERS

Q: Will you give my protected health information to my family or others?

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

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

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

Q: What should I do if I believe my privacy rights have been violated?

A: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may either:

1. Call us at the number listed above
2. File a written complaint with our Privacy Officer at the following address:
   Privacy Officer
   Blue Cross and Blue Shield of Minnesota
   3535 Blue Cross Road
   Eagan, MN 55122
3. Contact the Minnesota Department of Commerce at **(651) 539-1500** or **800-657-3602**
4. Contact the Minnesota Department of Health toll free **1-800-657-3916**
5. Notify the Secretary of the U.S. Department of Health and Human Services (HHS). Send your complaint to:
   Office for Civil Rights
   U.S. Department of Health and Human Services
   233 N. Michigan Ave., Suite 240
   Chicago, IL 60601
   Voice Phone **(312) 886-2359**,
   toll free **1-800-368-1019** Fax **(312) 886-1807**
   or TTY **(312) 353-5693**.
6. Call the HHS Voice Hotline number at **1-800-368-1019**

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

BlueCross BlueShield Minnesota

F7676R11 (08/19)

BlueCross BlueShield Minnesota