BlueCross BlueShield Minnesota

GROUP MEDICARE SUPPLEMENT PLAN WITH HIGH DEDUCTIBLE (PLAN F)

The Commissioner of Commerce, State of Minnesota has established two categories of Medicare Supplements. The two categories from most to least comprehensive are the Extended Basic Medicare Supplement Plan and the Basic Medicare Supplement Plan.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

RIGHT TO CANCEL: If you are not pleased with this certificate, you may cancel it by midnight of the 30th day after you receive it. To do so you must return the certificate and deliver or mail a written notice to Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, St. Paul, Minnesota 55164 or your Blue Cross agent. Mail must be postmarked by midnight of the 30th day, postage prepaid and properly addressed to us. We will then return all payments (including any fees or charges if applicable) made for this certificate within 10 business days after we receive the returned certificate and cancellation notice. The certificate will then be considered void from the beginning. However, if before the end of the 30day period you have incurred expenses and received coverage for claims in excess of the amount of your monthly premiums for that period, no refund will be made for that period.

Note to buyer:

THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

TERMINATION AND RENEWAL TERMS:

We will not cancel your coverage or refuse renewal because of the deterioration of your health.

This certificate's benefits and premiums may be allowed to lapse (for up to 24 months), upon your request, if you enroll in the Medicaid program, by notifying us in writing within 90 days of your enrollment in Medicaid. You may reinstate this certificate when Medicaid benefits end by notifying us in writing of your decision to reinstate this certificate within 90 days of the termination of Medicaid benefits.

We will also reinstate this certificate should the coverage lapse, if payment of the coverage costs is made no later than 60 days after the coverage costs were due unless:

- you have left the state or service area; or
- you have requested reinstatement on two or more prior occasions.

NOTICE: This certificate does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D.

Because of our concern 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 1-800-382-2000 (toll-free). 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.

နမ္ပါကတိၤကညီကျိာ်ဒီး, တါကဟ့ဉ်နၤကျိာ်တါမၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိါ, ကိး 711 တကွါ.

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.

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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 អ្នករាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih áǫįęęǫįóąǫąęįą. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

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

General Provider Payment Methods

Medigap, or Medicare supplement plans are designed to supplement traditional Medicare coverage. Payments to providers for Medicare covered services may be affected by the member's plan, Medicare's payment, and other Medicare requirements. In general, our payment is based on what Medicare approves and pays.

When Medicare is "primary" (pays before any other payer), Blue Cross and Blue Shield of Minnesota (Blue Cross) is the secondary payer. As the secondary payer, Blue Cross may pay up to the Medicare-approved amount, Medicare limiting charge, or a percentage of the Medicare Part A deductible.

When Medicare is not primary the following payment methods may apply.

Participating Providers

Blue Cross contracts with a large majority of doctors, hospitals and clinics in Minnesota to be part of its network. Other Blue Cross and/or Blue Shield Plans contract with providers in their states as well. (Each Blue Cross and/or Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.) Each provider is an independent contractor and is not an agent or employee of Blue Cross, another Blue Cross and/or Blue Shield Plan, or the Blue Cross and Blue Shield Association. These health care providers are referred to as "Participating Providers." They have agreed to accept as full payment (less deductibles, coinsurance and copayments) an amount that a Blue Cross and/or Blue Shield Plan has negotiated with its Participating Providers (the "Allowed Amount"). The Allowed Amount may vary from one provider to another for the same service.

Several methods are used to pay participating 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 Provider Payments (i.e. doctor visits, office visits) 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 charges or it may be based on 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 member patients. 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 Payments (i.e. hospital and other facility) 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"). The 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.

Pharmacy Payment

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

- the average wholesale price of the drug, less a discount, plus a dispensing fee; or
- the pharmacy's retail price; or
- 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

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with a Blue Cross or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under "Special Circumstances" below), the Allowed Amount 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 are responsible for paying the difference between the Blue Cross Allowed Amount and the Nonparticipating Provider's billed charges. This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

In determining the Allowed Amount for Nonparticipating Providers, Blue Cross makes no representations that this amount is a usual, customary or reasonable charge from a provider. See the Allowed Amount definition for a more complete description of how payments will be calculated for services provided by Nonparticipating Providers.

- **Example of payment for Nonparticipating Providers**

  The following table illustrates the different out-of-pocket costs you may incur using Nonparticipating versus Participating Providers for most services. The example presumes that the member deductible has been satisfied and that the Plan covers 80 percent of the Allowed Amount for Participating Providers and 60 percent of the Allowed Amount 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 Provider and Nonparticipating Provider could be more or less than the 40 percent difference in the following example.

	Participating Provider	**Nonparticipating Provider**
Provider charge:	$150	$150
Allowed Amount:	$100	$60
Blue Cross pays:	$80 (80 percent of the Allowed Amount)	$36 (60 percent of the Allowed Amount)
Coinsurance member owes:	$20 (20 percent of the Allowed Amount)	$24 (40 percent of the Allowed Amount)
Difference up to billed charge member owes:	None (provider has agreed to write this off)	$90 ($150 minus $60)
Total member pays:	$20	$114*

* Blue Cross will in most cases pay the benefits for any covered health care services received from a Nonparticipating Provider directly to the member based on the Allowed Amounts and subject to the other applicable limitations in the Plan. An assignment of benefits from a member to a Nonparticipating Provider generally will not be recognized. This figure, therefore, represents the net cost to the member after being reimbursed by Blue Cross.

- **Special Circumstances**

  When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the Allowed Amount and the provider's billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. This reimbursement also applies when you receive care in a nonparticipating hospital as a result of a medical emergency.

  - **Example of Special Circumstances**

    Your doctor admits you to the hospital for an elective procedure. Your hospital and surgeon are Participating Providers. You also receive anesthesiology services, but you are not able to select the anesthesiologist. The anesthesiologist is not a Participating Provider. When the claim for anesthesiology services is processed, Blue Cross may pay an additional amount because you needed care, but were not able to choose the provider who would render such services.

Above is a general summary of our provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary. Please note that some of these payment methodologies may not apply to your particular plan.

Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available on our website at www.bluecrossmn.com.

Women's Health and Cancer Rights

Under Minnesota law you are entitled to the following reconstructive surgery services following a mastectomy:

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 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.

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.

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 remain subject to any requirements outlined in Blue Cross' medical policy and/or federal law.

Blue Cross and Blue Shield of Minnesota Member Rights and Responsibilities

You have the right as a health plan member to:

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

You have the responsibility as a health plan member to:

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

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PREMIUMS, EFFECTIVE DATE, TERMS

Blue Cross and Blue Shield of Minnesota (herein called "we", "us", or "our") agrees that the person named as the subscriber on the identification (ID) card, herein called "you" or "your", is entitled to health services as herein defined subject to the terms of your certificate.

All Participating Providers have agreed to provide health services as herein defined.

The issuance of your certificate is subject to your being enrolled in both Part A and Part B of Medicare.

Your coverage starts on the date stated on the Declaration Page.

All terms of coverage shall start at 12:00 a.m. and end at 12:01 a.m. Standard Time the following day at the place where you live.

If you are a disabled Medicare beneficiary and covered under a group health plan, you may not need this Medicare supplement policy. The benefits and premiums under this Medicare supplement policy will be suspended during your enrollment in a group health plan. You must request this suspension in writing. When you lose group health plan coverage, your Medicare supplement policy will be reinstated if you request us to do so in writing within 90 days of losing group health plan coverage.

INTER-PLAN PROGRAMS

Out-of-Area Services

Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross' service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Blue Cross and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Blue Cross' service area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Nonparticipating Providers. Blue Cross' payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, Blue Cross will remain responsible for fulfilling Blue Cross' contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Nonparticipating Providers Outside Blue Cross' Service Area

1. Member Liability Calculation

When covered health care services are provided outside of Blue Cross' service area by Nonparticipating Providers, the amount you pay for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. Where the Host Blue's pricing is greater than the Nonparticipating Provider's billed charge or if no pricing is provided by a Host Blue, we generally will pay based on the definition of "Allowed Amount" as set forth in the "Definitions" section of this certificate. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Blue Cross will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, Blue Cross may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Blue Cross will pay for services rendered by Nonparticipating Providers. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Blue Cross will make for the covered services as set forth in this paragraph.

MEDICAL POLICY COMMITTEE

Our Medical Policy Committee determines whether new and existing medical treatments should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered.

For Medicare covered services, Medicare determines whether new and existing medical treatments should be covered.

For mental health services not covered by Medicare, we determine if the care is medically necessary. Medically necessary care means:

Health care services appropriate, in terms of type, frequency, level, setting, and duration, to the individual’s diagnosis or condition and diagnostic testing and preventive services. Medically necessary 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;
- help restore or maintain the enrollee's health; or
- prevent deterioration of the enrollee's condition; or
- prevent the reasonable likely onset of a health problem or detect an incipient problem.

DEFINITIONS

These terms have special meaning in this certificate.

Term	Definition
Accidental Injury	Bodily injury or injuries caused by an accident.
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.).
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 specified. 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 cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to us, and the percentage of the Allowed Amount paid by us is lower than the stated percentage for the covered service. If the payment to the provider is increased, we pay that cost on your behalf, and the percentage of the Allowed Amount paid is higher than the stated percentage.

The Allowed Amount for All Nonparticipating Providers

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

The Allowed Amount for Nonparticipating Providers in Minnesota

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the Allowed Amount will be based upon one of the following payment options to be determined at Blue Cross' discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar service; (2) a percentage, not less than 100%, of the Medicare Advantage Allowed Charge for the same of similar service; (3) a percentage of billed charges; or, (4) pricing based upon a nationwide provider reimbursement database. The payment option selected by Blue Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Cross.

The Allowed Amount for 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 Cross' 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 Cross may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by Blue Cross.

Term	Definition
	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 Cross may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law. 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 Member Service at the telephone number listed on the back of your member ID card for more information. For Medicare-eligible expenses, payment may be limited to the applicable Medicare Allowed Amount on assigned claims and the Medicare limiting charge on non-assigned claims. Under the Medicare program, "assignment" refers to providers who accept the amount Medicare approves for a certain service or supply as payment in full. "Allowed Amount" means the payment that Medicare approves for a specific service, and "Limiting Charge" refers to the amount (if any) a provider is permitted to charge over and above Medicare's approved payment amount.
Approved Bed	A bed which is certified by Medicare.
Attending Physician	A physician with primary responsibility for the care provided to a sick or injured person.
Benefit Period	A period which begins with the first day you are confined on an inpatient basis in a hospital or nursing facility, and ends after you have been out of the facility for 60 days in a row (including the day of discharge). A benefit period starts over when you re-enter a hospital or nursing facility more than 60 days after your last discharge.

Term	Definition
Coinsurance	The percentage of the Allowed Amount you must pay for certain covered services after you have paid any applicable copays until you reach your out-of-pocket maximum. For covered services from Participating Providers, coinsurance is calculated based on the lesser of the Allowed Amount or the Participating Provider's billed charge. Because payment amounts are negotiated with Participating Providers to achieve overall lower costs, the Allowed Amount for Participating Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the Allowed Amount for Participating Providers, the percentage of the Allowed Amount paid 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 amount will be based on the negotiated payment amount Blue Cross has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements Blue Cross may receive from other parties. Under the Medicare program, coinsurance refers to the percent of the Medicare approved amount that a beneficiary has to pay after the beneficiary pays any applicable deductible. The coinsurance payment is typically expressed as a percentage of the cost of the service.
Contracting Hospital	Any hospital that is a Participating Provider.
Cosmetic Surgery	Surgery and other services performed primarily to enhance or otherwise alter your physical appearance without correcting or improving physiological function.

Term	Definition
Custodial Care	Care which is designed chiefly to assist a person to meet her or his activities of daily living as defined by Medicare guidelines and determined by our medical staff and/or the hospital's, or the Medicare-approved skilled nursing facility's utilization review committee. Such care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled nursing service. Examples of custodial care include, but are not limited to: A. service which constitutes personal care such as walking and getting in or out of bed, aid in bathing, dressing, feeding and using the toilet; B. preparation of special diets; or C. supervision of medication which usually can be self-administered.
Diagnostic Admission	An admission to a hospital for the purpose of discovering or evaluating an illness rather than treatment.
Duration of Coverage	The period starting on the date your certificate starts and ending on the date your certificate ends.
Facility	A hospital, home health agency, skilled nursing facility, freestanding ambulatory facility, residential behavioral health treatment facility, or outpatient behavioral health treatment 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 facility.
Foot Orthotic	A rigid or semi-rigid orthopedic appliance or apparatus worn to support, align and/or correct deformities of the lower extremity.
Freestanding Ambulatory Facility	A facility that provides 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 facility is not part of a hospital, a clinic, a doctor's office, or other health care professional's office.
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, speech and occupational therapists, licensed registered dieticians, licensed nutritionists, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 clinics and doctors of medicine, osteopathy, chiropractic, or dental surgery.

Term	Definition
Health Service	Services and supplies that are reasonably priced, needed and usual for treatment of an illness as determined by us. A health service shall be deemed incurred on the date the services or supplies are rendered or received. Health services include services or supplies for reconstructive surgery resulting from illness of the involved body part.
Home Health Agency	A Medicare-approved facility that sends health professionals and home health aides into a person's home to provide health services.
Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Illness	A sickness, disease, or injury.
Investigative / Experimental	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: • 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; • 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); • 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.

Term	Definition
	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.
Medical Emergency	Medically necessary care which a reasonable lay person believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the member in serious jeopardy.
Medically Necessary and Appropriate	Eligible medical and hospital services that we determine are appropriate and necessary based on our internal standards. In disputed cases, we use the standard peer review process. For purposes of mental health care services, the following medically necessary definition applies: Health care services appropriate in terms of type, frequency, level, setting and duration to the individual's diagnosis or condition, diagnostic testing and preventive services. Medically necessary 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 conditions, procedures or treatment at issue; and • help restore or maintain the individual's health; or • prevent deterioration of the individual's condition; or • prevent the reasonable likely onset of a health problem or detect an incipient problem. For Medicare covered services, Medicare determines whether services are appropriate and necessary.
Medicare	The Health Insurance for The Aged Act, title XVIII of the Social Security Amendments of 1965, as amended, or title I, Part I, of Public Law Number 89-97 as enacted by the 89th Congress of the United States.
Medicare Eligible Expenses	Health care expenses allowed by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.
Mental Health Professional	A psychiatrist, psychologist, independent social worker, or marriage and family therapist, licensed for independent practice, that provides treatment for mental health disorders, alcoholism, chemical dependency, or drug addiction.

Term	Definition
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.), alcoholism, chemical dependency, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Participating Provider	A provider who has a service agreement with us. All providers participating with Blue Cross are Participating Providers.
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.
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 pharmacies, medical supply companies, independent laboratories and ambulances.
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.), alcoholism, chemical dependency or drug addiction. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
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.
Skilled Nursing Service	A service which is furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result as defined by Medicare guidelines. A service is not considered a skilled nursing service merely because it is performed or supervised by trained medical or paramedical personnel. However, it is a service which cannot be safely and adequately self-administered or performed by the average, rational, nonmedical person without the supervision of such personnel.
Supervised Employees	Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or a Minnesota Rule 29 clinic. The employing M.D., D.O., D.C., or D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

EXCLUSIONS

We will not allow benefits for:

- **services not allowed by Medicare as benefits, except as stated in the "Medicare Part A Supplemental Coverage", "Medicare Part B Supplemental Coverage" or "Additional Benefits" sections of this contract;**

- **services denied by Medicare, except as stated in the "Medicare Part A Supplemental Coverage", "Medicare Part B Supplemental Coverage" or "Additional Benefits" sections of this contract;**

- **services that would duplicate benefits provided by Medicare; and,**

- **all costs above Medicare's approved amounts.**

If you have any questions after reading *Medicare & You* and this contract, please call Customer Service at the phone number shown on the back of your ID card.

IMPORTANT INFORMATION

Your Medicare supplement health care coverage is called Medicare Supplement Plan with High Deductible (Plan F). This product was developed to help you pay for some of your health care expenses not paid in full by Medicare. *This coverage only pays for those services accepted and approved by Medicare.*

To understand your Medicare Supplement Plan F benefits, you must first understand your Medicare benefits. Therefore, it is very important that you also read *Medicare & You* carefully. If you do not have a Medicare Handbook, you may order one by calling your Social Security office.

Medicare benefits are divided into two categories: Medicare Part A and Medicare Part B.

- **Medicare Part A**

Medicare Part A helps pay for inpatient hospital care, skilled care in a nursing facility, home health care, and hospice services.

- **Medicare Part B**

Medicare Part B helps pay for physician services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by Medicare Part A. We offer you supplemental benefits in all these categories as stated in the "Benefits" section, with the addition of benefits for medically necessary emergency care outside the United States.

The Way Payment Works

When a provider agrees to accept the charge approved by Medicare as the most he or she will collect for covered services, he or she is said to accept *assignment*. If you are not sure if your providers accept assignment from the Medicare program, ask them and they will tell you.

If a provider does not accept assignment, he or she may collect more than Medicare's approved amount. When this happens, you are responsible for paying the difference between the approved amount and the billed amount.

If your provider accepts assignment, we will send our payment directly to that provider. If your provider does not accept assignment, we send our payments to you, or, in the event of your death, to your estate.

Filing Claims

You do not need to file a claim with Medicare for any services. By law, providers must fill out claim forms for you and send them to Medicare even if they do not accept assignment.

You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in Minnesota, Medicare will automatically send your claim to us.

- **Out-of-State Services**

If you receive health services outside of your home state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive an Explanation

of Medicare Benefits (EOMB). If the *Notes* section of the EOMB says that the information is being sent to your private insurer, we will automatically receive the EOMB.

If the EOMB does not say your private insurer is receiving the information, you need to send the EOMB to us so we can process your Medicare supplement benefits. Be sure your Medicare Supplement Plan F identification number and mailing address are shown accurately on the EOMB form. You do not need to complete a claim form. Just send the EOMB, and keep a copy for your own records. Send it to the address shown on the back of your I.D. card.

BENEFITS

Medicare Part A helps pay for most but not all of the services you receive in a hospital or nursing facility or from a home health agency or hospice program. Medicare Part B helps pay for some, but not all, doctor services and other medical services and supplies that are not covered under Medicare Part A. Your coverage with us helps pay for some of the remaining health care expenses.

Benefit Period

A benefit period under Medicare Part A is used to count the number of days you are covered for medically necessary services in a hospital or other facility primarily providing skilled or rehabilitation services.

There is a limit on how many days of hospital or nursing facility care Medicare helps pay for in each benefit period. However, it is possible to renew a benefit period. When your benefit period is renewed, your Part A protection is also renewed. Renewing a benefit period means that you begin a new benefit period.

During a benefit period, Medicare will help you pay for medically necessary covered services when you are an inpatient in a hospital for 90 days. If you are in the hospital for more than 90 days, then Medicare offers 60 lifetime reserve days you can use to help meet expenses.

- **When Benefit Periods Begin and End**

A benefit period begins on the first day you enter a hospital or nursing facility as an inpatient.

A benefit period ends after you have been out of the facility for 60 days in a row (including the day of discharge).

A benefit period starts over when you re-enter a hospital or nursing facility more than 60 days after your last discharge.

The following are two examples of how the benefit period works. The first example shows when the benefit period is renewed. The second example shows when the benefit period is not renewed.

Example 1
Benefit period is renewed

Let's say you enter the hospital on January 15. You are discharged on January 25. You use 10 days of your first benefit period. You are not hospitalized again until July 20.

Since more than 60 days passed between your hospital stays, you begin a new benefit period. This means your Medicare Part A coverage is completely renewed. Therefore, you have 90 eligible days to use in the new benefit period.

Example 2
Benefit period is <u>not</u> renewed

Let's say you enter the hospital January 15. You are discharged January 25. As before, you use 10 days of your first benefit period. However, you are then re-admitted to the hospital on February 20.

Since less than 60 days passed between hospital stays, your benefit period is not renewed. You are still in your first benefit period. The first day of your second admission (February 20) is counted as day 11 of hospital care in that benefit period. Therefore, you have 80 remaining eligible days in that benefit period. You will not begin a new benefit period until you have been out of the hospital (or nursing facility) for 60 consecutive days.

Medicare Part A Deductible

After you have satisfied the annual high deductible amount, we pay 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.

Medicare Part A Coinsurance

We will help pay for some of the expenses while you are in the hospital by supplementing Medicare's coverage. After you have satisfied the annual high deductible amount:

- **Days 61-90**

We pay 100% of the Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

- **Days 91-150**

We pay 100% of the Part A eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day you use. (See *Medicare & You* for an explanation of reserve days.)

- **365 Additional Days**

Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, we pay 100% of the Part A eligible expenses, subject to a lifetime maximum benefit of an additional 365 days.

Medicare Blood Deductible

After you have satisfied the annual high deductible amount, we pay, under Medicare Parts A or B, 100% of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations. Additional charges for blood are covered at 100% after you have met your Part B deductible.

Medicare Part B Deductible

After you have satisfied the annual high deductible amount, we pay all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

Medicare Part B Cost Sharing

After you have satisfied the annual high deductible amount, we pay 100% of the cost sharing amount of Medicare eligible expenses under Part B regardless of hospital confinement.

We pay 100% of the Part B coinsurance amount for Medicare Part B eligible preventive care services, and for the following cancer screening procedures at the intervals noted below:

- Mammograms: one (1) per calendar year
- Pap smears: one (1) per calendar year
- Flexible sigmoidoscopies and/or colonoscopies: one (1) per calendar year
- Fecal occult blood testing: one (1) per calendar year
- Prostate Specific Antigen (PSA) tests and digital rectal exams for men of all ages: one (1) per calendar year
- Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam): one (1) test per calendar year

Skilled Nursing Facility Days 21-100

After you have satisfied the annual high deductible amount, we pay 100% of the Part A coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled care received in a nursing facility eligible under Medicare Part A.

Hospice Services

After you have satisfied the annual high deductible amount, we pay 100% of the Medicare coinsurance or copayments for all Medicare Part A eligible expenses for hospice services.

Home Health Care Services

After you have satisfied the annual high deductible amount, we pay 100% of Medicare Part A and Part B home health services and medical supplies.

Foreign Travel

After you have satisfied the annual high deductible amount, coverage will be provided for 100% of medically necessary services and supplies for medical emergencies when traveling outside of the United States.

MEDICARE PART A SUPPLEMENTAL COVERAGE

When due to illness, and while your coverage is in force, if you receive any of the following health services, the following coverage will be furnished. The health services must be furnished while you are under the care of a physician who certifies that they are needed.

After you have satisfied your annual high deductible $2,340, coverage will be furnished for 100% of the following (please note that the annual high deductible amount shall be adjusted annually by the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year):

- Hospital Confinement Benefits:

  Coverage will be furnished for the Medicare Part A deductible.

  After satisfaction of the Medicare Part A deductible, coverage will be furnished for the Medicare Part A coinsurance amounts for hospital confinement and hospice care during a benefit period, and all Medicare Part A eligible expense for hospitalization not covered by Medicare. Coverage will also be furnished for the reasonable cost of the first three pints of blood (Medicare blood deductible), unless replaced in accordance with federal regulations or otherwise covered by this contract.

- Skilled Nursing Facility Confinement Benefits:

  Coverage will be furnished for the coinsurance amounts for Medicare Part A eligible expenses for the calendar year for skilled nursing facility care.

- Hospice and Respite Care Benefits:

  Coverage will be furnished for the Medicare Part A deductible and coinsurance amounts incurred by you for Medicare eligible hospice and respite care expenses.

- Home Health Care Services and Medical Supplies:

  Coverage will be furnished for the Medicare Part A deductible and coinsurance amounts incurred by you for Medicare eligible home health care services and medical supplies.

MEDICARE PART B SUPPLEMENTAL COVERAGE

When due to illness, and while your coverage is in force, if you receive any of the following health services, the following coverage will be furnished. The health services must be furnished while you are under the care of a physician who certifies that they are needed.

After you have satisfied your annual high deductible $2,340, coverage will be furnished for 100% of the following (please note that the annual high deductible amount shall be adjusted annually by the United States Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year):

- Coverage will be furnished for the Medicare Part B calendar year deductible.

- Coverage will be furnished for the eligible coinsurance expenses incurred by you for Medicare Part B approved charges. Coverage will also be furnished for the reasonable cost of the first three pints of blood (Medicare blood deductible), unless replaced in accordance with federal regulations or otherwise covered by this contract.

- Coverage will be furnished for 100% of the Medicare Part B deductible and Medicare Part B coinsurance amounts incurred by you for Medicare eligible home health care services and medical supplies.

- Coverage will be furnished for 100% of the cost sharing for Medicare Part B preventive services.

ADDITIONAL BENEFITS

Coverage is furnished for 80% of our Allowed Amount unless otherwise specified (not to exceed any charge limitations established by the Medicare program) for:

A. Residential Behavioral Health Treatment Program

Coverage is furnished for services and supplies received in a hospital or residential behavioral health treatment facility for the treatment of alcoholism, chemical dependency or drug addiction.

B. Outpatient Behavioral Health Treatment Program

Coverage is furnished for services and supplies in an outpatient behavioral health treatment facility for the treatment of alcoholism, chemical dependency or drug addiction.

C. Court Ordered Mental Health Treatment

Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or licensed psychologist is deemed medically necessary. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it determined to be medically necessary and otherwise covered under this certificate.

D. TMJ

Surgical and nonsurgical treatment of temporomandibular joint (TMJ) syndrome and craniomandibular disorder administered or prescribed by a physician or dentist are covered on the same basis as any other body joint.

E. Scalp Hair Prostheses (Wigs)

Hair loss must be due to alopecia areata. The maximum is one (1) prosthesis per person per calendar year.

F. Cancer Screening

Coverage will be provided for 100% of our Allowed Amount for services for routine screening procedures for cancer including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer,*pap smears, proctoscopy, occult blood work, prostate-specific antigen tests, and related office visits when ordered or performed by a physician in accordance with the standard practice of medicine.
*At risk for ovarian cancer means: 1) having a family history: a) with one (1) or more first or second degree relatives with ovarian cancer; b) of clusters of women relatives with breast cancer; or c) of nonpolyposis colorectal cancer; or 2) testing positive for BRCA1 or BRCA2 mutations. At risk for breast cancer" means: (1) having a family history with one or more first- or second-degree relatives with breast cancer; (2) testing positive for BRCA1 or BRCA2 mutations; (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (4) having a previous diagnosis of breast cancer.

G. Ventilator-Dependent Persons

Services up to 120 hours per hospital admission for services that are provided by a private duty nurse for a ventilator-dependent person in a hospital licensed under Chapter 144. The private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during the transition period to assure adequate training of hospital staff to communicate with the ventilator-dependent patient.

H. Reconstructive Surgery

Services for reconstructive surgery incidental to or following surgery resulting from an injury, sickness, or disease of the involved body part.

Under Minnesota law you are entitled to reconstructive surgery following a mastectomy if determined to be medically necessary by your attending physician, including: 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 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.

I. Immunizations

Immunizations unless covered under Part D of the Medicare program.

J. Foreign Travel

After satisfaction of the deductible, coverage will be provided for 100% of our Allowed Amount for medically necessary services and supplies for medical emergencies when traveling outside of the United States.

K. Management and Treatment of Diabetes

Physician prescribed equipment and supplies used for the management and treatment of gestational, type I or type II diabetes, including insulin, needles and syringes, unless covered under Part D of the Medicare program.

Coverage does not include nonprescription supplies such as alcohol swabs and cotton balls.

Coverage also includes diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

L. Treatment of Diagnosed Lyme Disease

Coverage is provided for the treatment of diagnosed Lyme disease.

M. Medicare Part B Expenses

Coverage is provided for eligible expenses and supplies not covered by Medicare Part B which exceed Medicare approved charges under the Medicare Part B Supplemental Coverage Section of this contract.

This provision does not include the Medicare Part B calendar year deductible or outpatient prescription drugs. Expenses may not exceed any charge limitations established by the Medicare Program or state law, and the Medicare approved Part B charge.

NONDUPLICATION PROVISIONS

Nonduplication with Medicare: Your certificate does not cover that part of any services and supplies for which Medicare has paid or would pay if coverage were requested by you, or for which you could have received payment if you had been enrolled in Medicare.

Nonduplication with Our Other Contracts: If you are covered under more than one of our contracts or certificates, coverage will be furnished under all of our contracts or certificates only to the extent that the combined coverage does not exceed the total charges for the health services.

Coordination of Benefits: If you have group coverage in addition to this certificate, the group coverage may be entitled to coordinate benefits. This means that you will never receive greater than 100% coverage of your claims, between the two contracts or certificates.

GENERAL PROVISIONS

Notice of Benefits Changes: We will notify you of modifications made to this certificate no later than 30 days before the annual effective date of any Medicare benefit changes. The notice will describe any benefit and coverage cost changes.

Your Identification: You must show your ID card to the Participating Provider at the time services are requested or not later than 30 days thereafter.

Time Limit on Certain Defenses: After two (2) years from the date of issue of this certificate, no misstatements, except fraudulent misstatements, made by the applicant in the application for such certificate shall be used to void the certificate or deny a claim for loss incurred or disability (as defined in the certificate) commencing after the end of such two (2) year period.

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 Cross, where necessary. We may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. 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.

Proof of Claim: You or the Participating Provider must give us written proof of claims for service within 90 days after the date such claims are incurred. We will not make such claim void if it is not reasonably possible to give us such proof within such 90-day period. In such case we will allow proof to be given within one year from the end of such 90-day period, except in the absence of legal capacity when this time period requirement is waived. We deem a service to be incurred on the date the services or supplies are received or rendered.

Claim Forms: When we receive your notice of claim, we will furnish you a claim form if one is necessary to process the claim. If we do not furnish you a claim form within 15 days, you will not need to provide us any further information. Claim forms are available by calling the toll-free Customer Service telephone number listed on the back of your identification card. You can also write us at the following address:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164

Payments Directly to Participating Providers: We will pay a Participating Provider directly for services he or she has given you. We will pay you directly for the services you receive from a Nonparticipating Provider. Benefits payable under this certificate for health services you receive from a Nonparticipating Provider will not be assignable to the Nonparticipating Provider. If a Nonparticipating Provider accepts Medicare's Allowed Amount as payment in full (assignment of claims), we will pay such provider directly for services he or she has given you.

Your Responsibility: According to Minnesota Statute 62C.14 subd.8, you have no debt to a Participating Provider who has given services except for those services or parts of services not covered by your certificate.

Physical Exams: We have the right to examine you at our expense as often as reasonably needed, during the pendency of a claim for any illness.

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

Entire Certificate: Your certificate, ID card and attached papers, make up the entire contract for coverage. You may ask to see the group contract at the group contractholder's office. Your group contractholder is the Plan contract at the group contractholder's office. Your group contractholder is the Plan Administrator for your coverage plan. We have discretionary authority to determine your eligibility for benefits and to construe the provisions of the group contract and this certificate.

Grace Period: We will grant you a period of 31 days from the due date on the initial bill for the payment of each premium. During such grace period, your certificate will remain in force. If we intend to cancel your certificate due to nonpayment of coverage costs, a written notice of our intent not to renew your certificate will be mailed to your last known address.

Reinstatement: If any renewal premium is not paid to us within the time granted, any future acceptance of payment by us or one of our agents shall reinstate the certificate, except as follows: if we or our agent require an application for reinstatement and issues to you a conditional receipt for your payment, your certificate will be reinstated upon approval by us of such application. If we do not mail to you a notice of our disapproval within 40 days after the issuance of the conditional receipt, your certificate will be reinstated on the forty-fifth (45) day following such issuance.

The reinstated certificate shall cover only loss caused by any injury which occurs after the date of reinstatement or a sickness which starts ten (10) days after such date. In all other respects, you and we shall have the same rights as you and we now have under your certificate except for any terms reached in connection with the reinstatement. Any payment made for reinstatement may be applied to a period for which payment had not previously been made, but not for more than sixty (60) days prior to the date or reinstatement.

Reimbursement and Subrogation: If we pay benefits for medical or dental expenses you incur as a result of any act of a third party for which the third party is or may be liable, and you later obtain full recovery, you are obligated to reimburse us for the benefits paid in accord with Minnesota Statutes 62A.095 and 62A.096.

Our right to reimbursement and subrogation is subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless we are separately

represented by our own attorney. If we are separately represented by an attorney, we may enter into agreement with you regarding your costs, disbursements and reasonable attorney fees and other expenses. If we cannot reach agreement on such allocation the matter shall be submitted to binding arbitration.

Nothing herein shall limit our right to recovery from another source which may otherwise exist at law. For purposes of this provision, full recovery does not include payments made by us or for your benefit.

If you make a claim against a third party for damages that include repayment for medical and medically related expenses incurred for your benefit, you must provide timely written notice to us of the pending or potential claim. We may, at our option, take such action as may be appropriate and necessary to preserve our rights under this reimbursement and subrogation provision, including the right to intervene in any lawsuit you have commenced with a third party. Notwithstanding any other law to the contrary, the statute of limitations applicable to our rights for reimbursement or subrogation does not commence to run until the notice has been given.

Changes to the Contract: All changes to the group contract must be approved by one of our executive officers and attached to the group contract with the group contractholder. No agent can legally change the group contract or waive any of its terms.

Conversion: This coverage is guaranteed renewable to the group contractholder. However, you may convert your coverage to an individual plan, at an individual rate, if your coverage ends because your group contract ends and is not replaced with other continuous group coverage within 30 days. You will not be required to pass health history screening.

Notice: Your certificate is not in lieu of or is in any way subject to or affecting any requirement for coverage by workers' compensation insurance.

Employee Retirement Income Security Act (ERISA) - Statement of Rights

If you are covered by a contract issued to your employment that is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated certificate of coverage. The administrator may make a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

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

4. Assistance with Your Questions

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

COMPLAINT PROCESS

Introduction

Blue Cross and Blue Shield of Minnesota has a process to resolve complaints. You can call or write us with your complaint. We will send a complaint form to you upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature. We will work to resolve your complaint as soon as possible using the process outlined below.

Medicare Appeals

If your complaint involves a dispute relating to the payment of services covered by Medicare, you may file a Medicare appeal through Medicare. The steps to follow in filing a Medicare appeal are explained in the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) forms which can be obtained from the Medicare intermediary or carrier. You may contact the Social Security office at 1-800-772-1213.

Definitions

Complainant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits a complaint.

Complaint means any grievance that is not the subject of litigation concerning any aspect of the provision of health services under your certificate. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former member, the complaint must relate to the provision of health services during the period of time the complainant was a member.

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

Any grievance that requires a medical determination in its resolution must have the medical determination aspect of the complaint processed under the utilization review process described below.

Process for issues related to enrollment, termination, premium payment or coverage of Medicare noneligible services

Verbal Notification

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 within 10 days. If our resolution of your oral complaint is wholly or partially adverse to you, we will provide you a complaint form that will include all the necessary information to file your complaint in writing. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

Written Notification

You may submit your complaint in writing, or you may request a complaint form that will include all the necessary information to file your complaint.

Blue Cross and Blue Shield of Minnesota will notify you that we have received your written complaint.

Within 30 days of receiving your complaint and all necessary information, we will notify you in writing of our decision and the reasons for the decision. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you in advance of the reasons for the extension.

You are entitled to examine all pertinent documents and to submit issues and comments in writing. If your health plan is subject to ERISA and our complaint determination is wholly or partially adverse to you, you may file suit in federal district court or use the voluntary appeal procedure below.

Voluntary Appeal

If our decision is partially or wholly adverse to you, you may file a voluntary appeal of the decision in writing and request either a hearing or a written reconsideration. Our appeals committee will not consist solely of the same person or persons who made the initial complaint decision that is being appealed.

Hearings include the receipt of testimony, correspondence, explanations or other information from you, staff persons, administrators, providers, or other persons as deemed necessary by the presiding person or persons for the fair appraisal and resolution of the appeal.

In the case of a hearing, concise written notice of our decision and all key findings will be given to you within 45 days after we receive your written notice of appeal.

Written reconsiderations include the receipt of correspondence, explanations or other information from you, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons conducting the appeal for the fair appraisal and resolution of the appeal.

In the case of a written reconsideration, concise written notice of our decision and all key findings will be given to you within 30 days after we receive your written notice of appeal.

If you request, we will provide you a complete summary of the appeal decision.

Process for Complaints When Utilization Review is Necessary

When a medical determination is necessary to resolve your complaint, we will process your complaint using these utilization review appeal procedures. Utilization review applies a well-defined process to determine whether health care services are medically necessary and eligible for coverage. Utilization review includes a process to appeal decisions not to cover a health care service.

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

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

Definitions

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 professional, for the purpose of determining the medical necessity of the services or admission.

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

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

Provider means 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.

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

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

Determinations

Standard review determination

When a medical determination is required, Blue Cross and Blue Shield of Minnesota's initial determination will be communicated to you and your provider within 10 business days of the request provided that all information reasonably necessary to make a determination on your request has been made available to us. When we authorize services, we notify the provider by telephone and in writing. When we determine not to authorize the services, we notify the attending health care professional and hospital by telephone, and notify the attending health care professional, hospital, and member in writing. Notification will include notice of the right to appeal and how to submit an appeal.

Expedited review determination

Blue Cross and Blue Shield of Minnesota will use an expedited review determination if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify the attending health care professional, hospital and member of the decision as expeditiously as the member's medical condition requires, but no later than 72

hours from the initial request. If the expedited determination is to not authorize services, notification will include notice that you and your attending health care professional may submit an expedited appeal, and how to submit an expedited appeal.

Appeals

Standard appeal

You or your attending health care professional may appeal Blue Cross and Blue Shield of Minnesota's decision to not authorize services in writing or by telephone. The decision will be made by a health care professional who did not make the initial decision. We will notify you and your attending health care professional of our determination within 30 days of receipt of your appeal.

The request for appeal should include:

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

Expedited appeal

When Blue Cross and Blue Shield of Minnesota does not authorize services under the expedited review determination procedure described above, and the attending health care professional believes that an expedited appeal is warranted, you and your attending health care professional may request an expedited appeal. You and your attending health care professional 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 professional 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 your health plan is subject to ERISA, and our appeal decision is wholly or partially adverse to you, you may file suit in federal district court.