Blue Plus Minnesota Value
Individual 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. 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

You may also deliver or mail a written notice to 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.

Renewal of This Contract

Coverage starts on the date specified in the lower right-hand corner of the front cover. This is the effective date for you and any eligible dependents who enroll on or before that date.

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 year unless the number of dependents covered under your contract changes.

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.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တက့ၢ်.

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

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

Notice of Nondiscrimination Practices

Effective July 18, 2016

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

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

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

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

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

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

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

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.

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.

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

Monica Engel

President and CEO

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. 1-800-531-6685
Blue Cross and Blue Shield of Minnesota Website	bluecrossmn.com
BlueCard Telephone Number	1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
BlueCard Website	bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
Pharmacy Telephone Number	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 bluecrossmn.com or by calling Customer Service at the telephone number above.

Identification (ID) Card

If your card is lost, stolen, or contains inaccurate information, please contact Customer Service immediately. You can also request additional or replacement cards online by logging in at bluecrossmn.com.

Table of Contents

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 plan. It is important that you read this entire benefit booklet carefully. If you have questions about your coverage, call Customer Service at the telephone number on the back of your ID card or log in at bluecrossmn.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 "Who is Eligible for Coverage."

This benefit booklet explains the health 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 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 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 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 plan member to:

- know your health 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

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 at the telephone number on the back of your ID card.

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 upon the plan's renewal date.

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 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.

Blue Plus Minnesota Value Individual Health Plan Contract

Networks	
Your online provider directory lists in-network providers in our service area and may change from time to time, 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. To find an in-network provider, log in at bluecrossmn.com or call Customer Service at the telephone number on the back of your ID card.	
In-network participating providers	Blue Plus Minnesota Value network providers
Out-of-network participating providers inside Minnesota	Blue Cross and Blue Shield of Minnesota (Blue Cross) participating providers
Out-of-network participating providers outside of Minnesota	BlueCard Traditional providers
In-network participating pharmacy providers	Essential pharmacy network
For more information on how your in-network providers work with your benefits, please refer to "How Your Program Works."	

Networks
Eligible services you receive from Indian Health Services (IHS), American Indian tribes, tribal organizations, Urban Indian Organizations, or services that are referred by Contract Health Services are covered in full. For eligible services you receive from providers outside of the Indian Health Services (IHS), American Indian tribe, tribal organizations, Urban Indian Organizations or services other than those referred by Contract Health Services, please refer to the information below on this "Benefit Overview" and on the "Benefit Charts."

General Provision		
Medical Benefits	**In-Network Providers**	**Out-of-Network Providers**
Deductible - Individual	You pay $1,100 per person per calendar year	You pay $20,000 per person per calendar year
Deductible - Family	You pay $3,300 per family per calendar year	You pay $40,000 per family per calendar year
Deductible – Embedded 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	Generally, you pay 50% coinsurance after deductible
After any applicable deductible is met, you will pay coinsurance, which is a percent of the allowed amount, until the out-of-pocket is met. Then, you pay nothing to the end of the calendar year when using participating providers. You may have to pay any charges that exceed the allowed amount when using nonparticipating providers.		
Out-of-pocket limit – Individual (includes prescription benefits)	You pay $7,500 per person per calendar year	Not applicable
Out-of-pocket limit – Family (including prescription benefits)	You pay $15,000 per family per calendar year	Not applicable
The following eligible medical and prescription costs are included in the out-of-pocket maximum: ● Deductibles ● Copays ● Coinsurance		
Out-of-Pocket Limit – Embedded If you have other family members on the plan, each family member must meet their own individual out-of-pocket limit until the total amount of out-of-pocket limits paid by all family members meets the overall family out-of-pocket.		
Lifetime Maximum (per member) ● If you live more than 100 miles from a provider eligible to perform a termination of pregnancy, there may be a benefit available for travel expenses directly related to covered plan benefits for the procedure	$2,500	
● 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	$5,000	
For more information about how your benefits for travel expenses work, call Customer Service at the telephone number on the back of your ID card.		

Prescription Drugs		
BasicRx Drug Benefits	**In-Network Providers**	**Out-of-Network Providers**
Affordable Care Act (ACA) Preventive Covered Prescription Drugs Please refer to: bluecrossmn.com/individualdruglist 2024 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
Tier 1 Prescription Drugs	**Retail pharmacy:** You pay $20 copay per prescription **90dayRx participating retail pharmacy:** You pay $60 copay per prescription **Mail service pharmacy:** You pay $60 copay per prescription If you receive services from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	NO COVERAGE
Tier 2 Prescription Drugs	**Retail pharmacy:** You pay $60 copay per prescription **90dayRx participating retail pharmacy:** You pay $180 copay per prescription **Mail service pharmacy:** You pay $180 copay per prescription	NO COVERAGE
Tier 3 Prescription Drugs	**Retail pharmacy:** You pay $180 copay per prescription **90dayRx participating retail pharmacy:** You pay $540 copay per prescription **Mail service pharmacy:** You pay $540 copay per prescription	NO COVERAGE
Tier 4 Prescription Drugs Designated specialty prescription drugs purchased through a specialty pharmacy network supplier.	**Specialty pharmacy network supplier:** You pay $540 copay per prescription	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.		

Benefit Chart

The health plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate and be in accordance with any treatment plan prescribed by the member's treating health care provider. 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.

Except as specifically provided in this health 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 or in the "General Exclusions."

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

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 because of the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in applicable Medical and Behavioral Health Policies and/or federal law.

Women's Health and Cancer Rights Act

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

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. 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 Telehealth Services

We cover eligible telehealth at the same benefit level that would apply if the services were provided in-person. For example, office visits are covered at the office visit benefit level, inpatient services are covered at the inpatient services benefit level and behavioral health services are covered at the corresponding behavioral health services benefit level. The plan covers telemonitoring services when:

1. the telemonitoring service is medically appropriate based on the member’s medical condition or status;
2. the member is cognitively and physically capable of operating the monitoring device or equipment, or the member has a caregiver who is willing and able to assist with the monitoring device or equipment; and
3. the member resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Unrestricted Access for Rare Disease

If you or your dependent believe you have a rare disease, call Customer Service at the telephone number on the back of your ID card. We will connect you with our care management team.

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

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

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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	
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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	

Ambulance – Notes

1. Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

   a. from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
   b. between hospitals; or
   c. between a hospital and a skilled nursing facility provider

   when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
2. Transportation and related emergency 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.
3. Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.

Ambulance – Not Covered

1. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility capable of treating your condition (example: facility A is the closest medical facility capable of treating your condition, but you are transported to facility B. We will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you are transported by ambulance to facility B, the cost of transportation 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).
2. Ambulance transportation services that are not medically necessary for basic or advanced life support.
3. Transportation services, including ambulance services that are mainly for your convenience.
4. Transportation to a residence.
5. Conventional air services, such as commercial airlines.

Behavioral Health Mental Health Care

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

Under the federal Mental Health Parity and Addiction Equity Act as amended and its implementing regulations, and Minnesota Statutes Section 62Q.47, members have the right to parity in mental health and substance use disorder benefits. If you have questions or concerns, call Customer Service at the telephone number on the back of your ID card, or you can also file a complaint with Blue Plus or the Minnesota Department of Health.

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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● Assessment and diagnostic services such as psychological /neuropsychological testing and evaluation ● All other professional services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Outpatient hospital/outpatient behavioral health treatment facility services including: ● Assessment and diagnostic services ● Individual/group/family therapy ● Crisis evaluations ● Observation beds	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Professional health care services including: ● Clinic-based partial programs ● Clinic-based day treatment ● Clinic-based intensive outpatient program (IOP)	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● Inpatient health care professional services	You pay 20% coinsurance after	You pay 50% coinsurance after

The Plan Covers	In-Network Providers	Out-of-Network Providers
• Inpatient hospital/inpatient behavioral health treatment facility services including: ■ all eligible inpatient services • Inpatient residential behavioral health treatment facility services	deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	deductible

Behavioral Health Mental Health Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a licensed psychiatrist or a doctoral level licensed psychologist is deemed medically necessary and appropriate. 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.
3. Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
4. 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" means:
   a. "an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the state commissioner of human services; and
   b. seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation."
5. 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.
6. Coverage is provided for crisis evaluations delivered by mobile crisis units.
7. 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.
8. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
9. For home health related services, please refer to "Home Health Care."
10. 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."
11. Coverage is provided for outpatient Certified Peer Specialist and Certified Family Specialist services (otherwise known as peer support services).

Behavioral Health Mental Health – Not Covered

1. Services for or related to mental illness not listed in the most recent edition of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).
2. Services for or related to intensive behavioral therapy programs, including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Applied Behavior Analysis (ABA), Intensive Behavioral Intervention (IBI), and Lovaas Therapy for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor.

Behavioral Health Mental Health – Not Covered
3. 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 provided under Minnesota law.
4. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations, parenting assessments, educational classes for driving under the influence (DUI)/driving while intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.
5. Services or room and board for foster care, group homes, shelter care, lodging programs, halfway house, and services.
6. Services for skills training.
7. Services for or related to marriage/couples counseling or training for the primary purpose of relationship enhancement including, but not limited to, premarital education; or marriage/couples retreats, encounters, or seminars.
8. Services primarily educational in nature, except nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders not otherwise specified (NOS).
9. 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).
10. Educational services for the treatment of learning disabilities.
11. Services for therapeutic day care and therapeutic camp services.

Behavioral Health Substance Use Care

Under the federal Mental Health Parity and Addiction Equity Act as amended and its implementing regulations, and Minnesota Statutes Section 62Q.47, members have the right to parity in mental health and substance use disorder benefits. If you have questions or concerns, call Customer Service at the telephone number on the back of your ID card, or you can also file a complaint with Blue Plus or the Minnesota Department of Health.

The Plan Covers	In-Network Providers	Out-of-Network Providers
Outpatient health care professional services including: ● Office visit ● Individual/group/family therapy	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● Outpatient hospital/outpatient behavioral health treatment facility services including: ■ intensive outpatient programs (IOP) and related aftercare services ■ partial hospitalization ● Inpatient health care professional services ● Inpatient hospital facility services ● Residential behavioral health treatment facility services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Behavioral Health Substance Use Care – Notes

1. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
2. Benefits are provided for admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold.
3. Coverage is provided for chemical dependency treatment provided to a member by the Department of Corrections while the member is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under Minnesota Statutes Section 169A.24 if:
   a. a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes Section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and
   b. the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination.
4. 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.

Behavioral Health Substance Use Care – Notes
5. A substance use disorder service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts. 6. For home health related services, please refer to "Home Health Care." 7. 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." 8. For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." 9. Coverage is provided for outpatient Certified Peer Recovery and Certified Family Specialist services (otherwise known as peer support services).

Behavioral Health Substance Use Care – Not Covered
1. 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). 2. Evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations, parenting assessments, educational classes for driving under the influence (DUI)/driving while intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs. 3. Services or room and board for foster care, group homes, shelter care, and lodging programs, and halfway house services. 4. Services for skills training. 5. 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 – including office visit	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Other chiropractic services – including therapies	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Chiropractic Care – Notes

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

Chiropractic Care – Not Covered

1. 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.
2. 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.
3. 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.
4. Services for or related to therapeutic massage.
5. Maintenance services.
6. 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.

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 including: ■ dental implants ■ removal of impacted teeth or tooth extractions ■ related orthodontia ■ related oral surgery ■ bone grafts ● Diagnostic evaluation, surgical, and nonsurgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD)	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Dental Care – Notes

1. 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 includes, but is not limited to:
   a. initial exam and x-rays
   b. restorations (not replacements)
   c. root canal procedure
   d. crowns
   e. surgical procedures and extraction (removal)
2. Bone grafts (the building up of bone in the upper or lower jaw) 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.
3. Sound natural teeth means teeth and tissue that are viable, functional and free of disease. A sound natural tooth:
   a. has no decay,
   b. has no filling on more than two surfaces,
   c. does not have bone loss of more than 50%,
   d. has not had a root canal procedure (removing the tissue inside the tooth root),
   e. has not been replaced by any artificial means (for example, implants, fixed or removable bridges, dentures, dental appliance, or crowns)
4. The health 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; 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.

Dental Care – Not Covered

1. Services for or related to orthodontia, except for treatment of cleft lip and palate.

Dental Care – Not Covered
2. Services for or related to treatment of cracked or broken teeth due to biting or chewing.
3. Dentures, regardless of the cause or the condition, and any associated services, including bone grafts.
4. Dental implants, and associated services, except when related to services for cleft lip and palate.
5. Accident-related dental services initiated after 12 months from the date of injury or initiated after 12 months from the effective date of coverage; accident-related dental services occurring more than 24 months after the date of when treatment or restoration is initiated.
6. Services for or related to replacement of a damaged dental bridge from an accident-related injury.
7. Osteotomies (cutting of the bone), osteoplasty (building up the bone), and other procedures associated with the fitting of dentures or dental implants.
8. Services for or related to removal of impacted teeth, tooth extractions, and/or root canal procedure, including but not limited to imaging studies, preoperative examinations, and anesthesia.
9. Services for or related to dental or oral care, surgery, supplies, and bone grafts, except for limited dental services as noted in this benefit chart.
10. Services to treat bruxism (excessive grinding of teeth or clenching of the jaw), including dental splints.
11. Services for routine dental care.
12. Services for or related to non-covered dental services such as anesthesia and facility charges except as noted in this benefit chart.
13. Services for or related to gingival and periodontal (the gums and bone that surround and support the teeth) procedures.

Emergency Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
Outpatient health care professional services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after in-network deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	
Outpatient hospital/facility services to treat an emergency medical condition as defined in Minnesota law	You pay 20% coinsurance after in-network deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	

Emergency Care – Notes

1. 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.
2. 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.
3. If the care you receive is due to a medical emergency, prior authorization is not required.
4. Please refer to "Terms You Should Know" for a definition of medical emergency.
5. For follow-up care, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."
6. For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services."
7. For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services."

Gender Affirming Care

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

The Plan Covers	In-Network Providers	Out-of-Network Providers
Outpatient health care professional services including: ● Office visit ● Counseling	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Gender Affirming Care – Notes

1. Gender affirming care includes but is not limited to breast/chest procedures, genital procedures, facial procedures, thyroid cartilage reduction, voice therapy, hair removal, and hormone therapy. These services are covered when they are medically necessary and appropriate for the treatment of gender dysphoria.
2. Services include related preparation and follow-up care.
3. Gender-specific preventive services are covered for transgender and gender diverse people appropriate to their anatomy. For preventive care services, please refer to “Preventive Care.”
4. For prescription drugs for gender affirming care, please refer to "Prescription Drugs."
5. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
6. For laboratory and diagnostic imaging services billed by a health care 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."
7. For therapeutic injections, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services."
8. For more information call Customer Service at the telephone number on the back of your ID card or visit bluecrossmn.com/gendercare.

Home Health Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
Skilled care and other home care services ordered by a physician and provided by employees of an approved home health 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 dietitian ● Services provided by a respiratory therapist ● Services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with covered services ● Home health care following early maternity discharge ● Palliative care	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	NO COVERAGE

Home Health Care – Notes
1. Home health care services are subject to a limit of 120 visits per person per calendar year. The one home health care visit following early maternity discharge does not apply to the 120 visits limit.
2. 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 days following the discharge of the mother and her newborn child.
3. Benefits for home infusion therapy and related home health care are listed under "Infusion Therapy."
4. For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies."
5. 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 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.
6. Skilled Nursing Care - Intermittent Hours consist of up to two 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.
7. If you are also enrolled in the Minnesota Medical Assistance Program, you may be eligible for additional skilled nursing care.
8. Intermittent skilled nursing care consists of up to two consecutive hours of care per date of service in the member's home.

Home Health Care – Not Covered
1. Services you receive from an out-of-network provider.
2. Homemaker services.
3. Maintenance services.
4. Services for dialysis treatment you receive from a home health care agency.
5. Services for custodial care you receive from a home health care agency.
6. Services for food or home-delivered meals you receive from a home health care agency.
7. Services for or related to extended hours home care, except as noted above (please refer to "Extended Hours Skilled Nursing Care" in "Terms You Should Know").

Hospice Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
Hospice care for a terminal condition	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	NO COVERAGE

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

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

Hospital Inpatient Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
• Hospital room and board and general nursing services • Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients • Use of operating, delivery, and treatment rooms and equipment • Anesthesia, anesthesia supplies, and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery • Medical and surgical dressings, supplies, casts, and splints • Prescription drugs provided to you while you are inpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives • Diagnostic services • Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons • Therapy and rehabilitation services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Hospital Inpatient – Notes
1. The health plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition. 2. The plan covers 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." 3. 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: a. potential donor testing b. donor evaluation and work up c. hospital and professional services related to organ procurement. 4. Diagnostic services include the following when ordered by a health care provider: a. diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine b. diagnostic pathology consisting of laboratory and pathology tests c. diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Blue Plus d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Hospital Inpatient – Notes
5. 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; 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.

Hospital Inpatient – Not Covered
1. Services for inpatient admissions which are primarily for diagnostic studies.
2. Personal comfort items such as telephone, television.
3. Travel expenses for a kidney donor.
4. Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this plan.
5. Kidney donor expenses when the recipient is not covered for the kidney transplant under this plan.
6. Communication services provided on an outpatient basis or in the home.
7. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as noted in this benefit chart (please refer to "Extended Hours Skilled Nursing Care" in "Terms You Should Know").

Hospital Outpatient Care

The Plan Covers	In-Network Providers	Out-of-Network Providers

• Outpatient hospital/facility services
• Surgeon or assistant at surgery
• Use of operating, delivery, and treatment rooms and equipment
• Medical and surgical dressings, supplies, casts, and splints
• Radiation and chemotherapy
• 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 including:
  ■ facility billed services
  ■ facility laboratory services
  ■ facility diagnostic imaging services
• Prescription drugs 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
	If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing
		You pay 50% coinsurance after deductible

Facility billed free-standing ambulatory surgical center services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Hospital Outpatient – Notes
1. The health plan covers anesthesia and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five; 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.
2. 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.
3. 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.

Hospital Outpatient – Notes
4. 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.
5. 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 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.

Hospital Outpatient – Not Covered
1. Services and prescription drugs for or related to assisted reproduction.

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 home infusion therapy
	You pay 20% coinsurance after deductible
	If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing
		NO COVERAGE

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

Infusion Therapy – Not Covered
1. Services you receive from an out-of-network provider. 2. Home infusion services or supplies not specifically listed as covered services. 3. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy.

Maternity Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
Prenatal hospital/facility 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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● Postpartum care ■ office visit	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● All other eligible professional services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Inpatient hospital/facility services for: ● Delivery in a hospital/facility ● Postpartum care	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Maternity Care – Notes
1. 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.
2. Normal pregnancy – normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
3. 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. Services related to miscarriage, ectopic pregnancy or those that require cesarean section are covered as a delivery.

Maternity Care – Notes
4. Prenatal care - the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, gestational diabetes screening, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic services issued by the American College of Obstetricians and Gynecologists.
5. Postpartum care – comprehensive postnatal visits to provide a full assessment of the mother's and infant's physical, social, and psychological well-being. Covered services include but are not limited to care for mood and emotional well-being, infant care and feeding, sexuality, contraception, birth spacing, sleep and fatigue, physical recovery from birth, chronic disease management, and health maintenance.
6. 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 plan.
7. Under federal law, this health plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows: a. inpatient hospital coverage for the mother if covered under this health plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one home health care visit within four days after discharge from the hospital is covered under this health plan. Please refer to "Home Health Care." b. inpatient hospital coverage for newborn, if added to the health plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one home health care visit within four days after discharge from the hospital is covered under this health plan. Please refer to "Home Health Care."
8. Under federal law, the health plan may require that a provider obtain authorization from the health plan for the portion of a stay after the 48 hours or 96 hours, as applicable, mentioned above.
9. If you live more than 100 miles from a provider eligible to perform a termination of pregnancy, there may be a benefit available for travel expenses directly related to covered plan benefits for the procedure.
10. Please refer to "Who is Eligible for Coverage" to determine when the newborn's coverage will begin if the newborn is added to the plan.
11. 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."

Maternity Care – Not Covered
1. Health care professional services for childbirth deliveries in the home.
2. Services for or related to adoption fees.
3. Services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted reproduction, prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan.
4. Services for childbirth classes.
5. Services for donor ova or sperm.
6. 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.
7. Services for or related to elective cesarean (C-) section for the purpose of convenience.
8. Services and prescription drugs for or related to the selection of gender in embryos.
9. 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)
• Equipment and supplies for diabetes treatment including, but not limited to:
  ■ blood glucose monitors
  ■ monitor supplies
  ■ insulin infusion devices
• Prosthetics, such as breast prosthesis, artificial limbs, and artificial eyes
• 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
• Hearing aids for a hearing loss that cannot be corrected by other covered procedures. Maximum of one hearing aid for each ear every three years
• Custom foot orthoses
• Amino acid-based elemental formula
• Special dietary treatment for phenylketonuria (PKU) when recommended by a physician
• Wigs (scalp hair prostheses) for hair loss due to alopecia areata only Maximum of one wig per person per calendar year
	You pay 20% coinsurance after deductible
	If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing
		You pay 50% coinsurance after deductible

Corrective lenses prescribed for children age 18 and younger as follows: • eyeglasses (lenses and frames); maximum of one standard frame and one pair of lenses per person per calendar year (see NOTES below); or • contact lenses; maximum of one pair of contact lenses or one year's 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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	NO COVERAGE

Medical Equipment and Supplies – Notes
1. You are required to obtain prior authorization for specific durable medical equipment when you use nonparticipating providers in Minnesota and any provider outside of Minnesota. Please refer to bluecrossmn.com/priorauth or call Customer Service at the telephone number on the back of your ID card.

Medical Equipment and Supplies – Notes
2. The plan covers the approved rental or purchase, fitting, necessary adjustments, repairs, and replacements of durable medical equipment and supplies, including, but not limited to: a. prosthetic devices which replace all or part of an absent body part and its adjoining tissues or replace all or part of the function of a permanently inoperative or malfunctioning body part (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered b. a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part c. supplies and accessories necessary for the effective functioning of covered durable medical equipment. 3. Rental costs cannot exceed the total cost of purchase. 4. 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 when unable to digest or tolerate whole proteins found in other formulas, due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas are Neocate®, EleCare®, PurAmino™ (formerly Nutramigen® AA™ LIPIL), Vivonex®, Tolerex®, Alfamino, and E028 Neocate Splash. 5. Participating providers maintain a "collection" of standard frames to choose from for corrective lenses for children age 18 and younger. Premium frames that are not included in the "standard collection" are not covered.

Medical Equipment and Supplies – Not Covered
1. Durable medical equipment, supplies, and prosthetics for convenience, personal, or recreational use. 2. Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants. 3. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps. 4. Repair, maintenance or replacement of rental equipment as this is included in the price of the rental. 5. Replacement of properly functioning durable medical equipment. 6. Duplicate equipment, prosthetics, or supplies. 7. Pre-fabricated or over-the-counter orthoses. 8. Blood pressure monitoring devices. 9. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate. 10. Services for or related to hearing aids or devices, except as noted in this benefit chart. 11. Devices for maintenance services. 12. Wigs (scalp hair prostheses) for any diagnosis other than alopecia areata. 13. Services for or related to lenses, frames, contact lenses, other fabricated optical devices, and professional services for fitting, except as noted in this benefit chart. 14. Charges for corrective lenses (including frames) for children age 18 and younger from an out-of-network provider. 15. Charges for premium frames for corrective lenses for children age 18 and younger that are not included in the "standard collection." 16. Biofeedback devices in the home.

Office Visit and Professional Services

The Plan Covers	In-Network Providers	Out-of-Network Providers
Physician office visits	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● E-visits ● Telephone consultations	You pay nothing If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Urgent care center visits for illness/injury ● Professional services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Retail health clinic ● Office visits	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● Laboratory services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
● All other professional services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

The Plan Covers	In-Network Providers	Out-of-Network Providers
Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Allergy extract and allergy injections including: ● Allergy testing ● Allergy serum ● Allergy injections	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Professional billed services received at a free-standing ambulatory surgical center	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible
Medication Therapy Management (MTM)	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	NO COVERAGE

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 • Assistant surgeon or registered nurse first assistant • Kidney and cornea transplant • Therapeutic drugs (for example, injections, 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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Office Visit and Professional Services – Notes

1. Physician services include services of an optometrist and an advanced practice nurse when performed within the scope of licensure.
2. Diabetes Self-Management Education and Support (DSMES) Services: When your health care provider certifies that you require diabetes education and support, coverage is provided for the following situations when rendered through DSMES services:
   a. when diabetes is diagnosed
   b. when a new medication is prescribed
   c. when diagnosed with diabetes and are at risk for complications including but not limited to having problems controlling your blood sugar, been treated in the emergency room or experienced a hospital stay, diagnosed with eye disease related to diabetes, experiencing lack of feeling in your feet or other foot problems, or been diagnoses with kidney disease related to diabetes
   d. DSMES may be provided individually or in a group setting.
3. If more than one surgical procedure is performed during the same operative session, 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 preoperative and postoperative care.
4. The plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
5. You are entitled to receive care for the following services at the in-network level of benefits from any qualified licensed provider:
   a. voluntary planning of the conception and bearing of children;
   b. diagnosis of infertility (the medically documented inability to conceive for 12 months);
   c. testing and treatment of a sexually transmitted disease; or
   d. testing of AIDS or other HIV-related conditions.
6. For kidney transplants done in conjunction with an eligible major transplant, please refer to "Transplant."
7. 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:
   a. potential donor testing;
   b. donor evaluation and workup; and
   c. hospital and professional services related to organ procurement.

Office Visit and Professional Services – Notes
8. Eligible therapeutic drugs, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug and the medication are billed by the health care provider are eligible under the "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 drugs includes coverage for off-label prescription drugs used for cancer treatment as specified by law. An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. Prescription drugs will not be excluded on the grounds that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law.
9. The plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
10. Office visits may include medical history; medical examination; medical decision making; testing; counseling; coordination of care; nature of presenting problem; physician time; or psychotherapy.
11. The plan covers hearing aid examinations/fitting/adjustments when hearing aids are covered by the plan.
12. 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 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.
13. 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. For more information about virtual care options, go to bluecrossmn.com/virtualcare or call Customer Service at the telephone number on the back of your ID card.
14. A retail health clinic, located in a retail establishment or worksite, provides medical services for a limited list of eligible symptoms (for example, 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.
15. 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 and Behavioral Health Policy guidelines are available at bluecrossmn.com or by calling Customer Service at the telephone number on the back of your 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 from step therapy may be requested. The step therapy override request form and a description of the step therapy override process is available at bluecrossmn.com or by calling Customer Service at the telephone number on the back of your 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 drug if it is a covered prescription drug under your plan.
16. For self-administered prescription drugs, please refer to "Prescription Drugs."
17. The plan covers services for or related to growth hormone replacement therapy.
18. Medication Therapy Management (MTM) services are covered only when using in-network providers. Covered services are limited to a maximum of three services per person per calendar year from all in-network providers combined.

Office Visit and Professional Services – Not Covered
1. Services for autopsies.

Office Visit and Professional Services – Not Covered
2. Repair of scars and blemishes on skin surfaces. 3. 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. 4. Out-of-network provider-initiated communications. 5. Separate services for preoperative and post-operative care for surgery billed by an out-of-network provider. 6. 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 described in "Reconstructive Surgery." 7. Services for or related to travel expenses for kidney donor. 8. Kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this benefit booklet. 9. Kidney donor expenses when the recipient is not covered under this benefit booklet. 10. Services and prescription drugs for or related to assisted reproduction. 11. Services for or related to reversal of sterilization. 12. 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. 13. Services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.

Physical, Occupational, and Speech Therapy

The Plan Covers	In-Network Providers	Out-of-Network Providers
Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech, or language pathologist	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	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 If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Physical, Occupational, and Speech Therapy – Notes

1. Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
2. For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
3. Office visits include an evaluation or re-evaluation for the following therapies:
   a. physical
   b. occupational
   c. speech
   d. swallowing.
4. 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."

Physical, Occupational, and Speech Therapy – Not Covered

1. 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.
2. 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 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: bluecrossmn.com/individualdruglist2024 for the list of covered drugs ● FDA-approved tobacco cessation drugs and products, subject to limitations below ● 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"

Prescription Drugs – Notes
1. The covered drug list is available at bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your ID card.
2. Insulin listed on tier 1 and tier 2 of the covered drug list are covered at zero cost-sharing.
3. Covered prescription drugs include drugs listed in your health 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").
4. The Blue Plus covered drug list is 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.
5. Some medications may be subject to a quantity limitation per day supply or to a maximum dosage per day.

Prescription Drugs – Notes

6. 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.
7. The drug list is subject to periodic review and modification by Blue Plus or a designated committee of physicians and pharmacists.
8. 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.
9. 90dayRx includes the following: a retail pharmacy participating in the 90dayRx network and a participating mail service pharmacy. Eligible prescription drugs are dispensed up to a 93-day authorized supply of ongoing, long-term prescription drugs.
10. The plan covers a range of FDA-approved preventive contraceptive methods for women with reproductive capacity. Benefits are provided for up to a 12-month supply for covered contraceptives, other than over-the-counter and emergency contraceptives, when prescribed by your provider for the prevention of pregnancy. Medical management may apply. Please also refer to "Preventive Care."
11. 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.
12. For more information regarding contraceptive or ACA preventive prescription drug coverage, visit bluecrossmn.com/individualdruglist2024 or call Customer Service at the telephone number on the back of your ID card.
13. Blue Plus applies medical management in determining which contraceptives are included on your covered drug list, as well as a subset of contraceptive medications that are covered at zero cost-sharing. If your prescribing health care provider determines that none of the contraceptive medications covered at zero cost-sharing are clinically appropriate for you, they may request an exception. If the exception request is approved, the contraceptive medications are eligible for zero cost-sharing. To view a current list of contraceptive medications that are covered at zero cost-sharing under your plan visit bluecrossmn.com/preventivecare or call Customer Service at the telephone number on the back of your ID card.
14. Covered prescription drugs include:
    a. 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 "Claims Process;"
    b. those which, under federal law, are required to bear the legend: "Caution: federal law prohibits dispensing without a prescription;"
    c. legend prescription drugs under applicable state law and dispensed by a licensed pharmacist; and
    d. certain prescription drugs that may require prior authorization from Blue Plus.
15. 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 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 bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your 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.
16. 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 at bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your ID card.

Prescription Drugs – Notes

17. 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 at bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your 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 at bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your 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.
18. The plan will cover a 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.
19. The health 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.
20. Oral chemotherapy medications are covered according to the benefits listed in the “Prescription Drug Benefits” in “Benefit Overview” and they are only listed on non-specialty drug tiers, even when they are purchased from a specialty pharmacy.
21. 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:
    a. 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 year when the prescription drug is removed from your covered drug list, and if:
        i. 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 plan;
        ii. the prescribing health care provider indicates that the prescription must be DAW; and
        iii. the prescribing health care provider certifies in writing to us that the prescription drug prescribed will best treat your condition.
    b. 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.
22. 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.
23. Amino acid-based elemental formula is considered a supply item. Please refer to "Medical Equipment and Supplies."
24. Biosimilar drugs are not considered generic drugs. Please refer to your covered drug list.
25. There may be circumstances where early or extended prescription drug refills are available. Call Customer Service at the telephone number on the back of your ID card for further information. Restrictions apply.
26. We may receive pharmaceutical manufacturer volume discounts or reimbursements in connection with the purchase of certain prescription drugs covered under the health 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.

Prescription Drugs – Notes
27. If you are prescribed a prescription drug when there is an equivalent lower cost prescription drug or biosimilar, you will also pay the difference in cost between the prescribed prescription drug and the lower cost prescription drug or biosimilar, 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 or biosimilar, 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 or biosimilar in addition to the cost-sharing amounts that apply. Certain prescription drugs are not covered when an equivalent lower cost prescription drug or biosimilar is available. You are also responsible for the payment differential when a lower cost prescription drug or biosimilar is authorized by the physician and you purchase an equivalent higher cost prescription drug. This includes prescription drugs that have been approved for coverage, such as through the exception or prior authorization process. The covered drug list is available at bluecrossmn.com/individualdruglist2024 or by calling Customer Service at the telephone number on the back of your ID card.
28. 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.
29. There may be circumstances where early or extended prescription drug refills are available. Call Customer Service at the telephone number on the back of your ID card for further information. Restrictions apply.
30. For prescription drugs dispensed and used during a covered hospital stay, please refer to "Hospital Inpatient Care."
31. For supplies or durable medical equipment, except as provided in this "Benefit Chart," please refer to "Medical Equipment and Supplies."
32. Digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional drug therapies, for disease prevention and management) when dispensed through a pharmacy and deemed eligible for coverage.

Prescription Drugs – Not Covered
1. Any prescription for more than the retail days' supply or 90dayRx days' supply as outlined in the "Benefit Overview," except as described in "Prescription Drugs – Notes."
2. Charges for mail service drugs that are not purchased through an in-network mail service pharmacy.
3. Prescription drugs and drug therapy supplies which are not included on your covered drug list, except for designated ACA preventive drugs; off-label prescription drugs used for cancer treatment; or prescription drugs approved through the exception process, as noted in this benefit chart.
4. Specialty drugs not purchased through a specialty pharmacy network supplier.
5. Drugs removed from the covered drug list due to safety reasons may not be covered.
6. Tobacco cessation drugs and products without a prescription.
7. Medical devices approved by the FDA under the prescription drug benefit unless the devices are on your covered drug list. For covered medical devices that are generally submitted and reimbursed under your medical benefits, please refer to "Medical Equipment and Supplies."
8. Services and prescription drugs for or related to assisted reproduction.
9. Prescription drugs for the treatment of sexual dysfunction including, but not limited to erectile dysfunction.
10. Cosmetic alteration medications/drugs.
11. Weight loss medications/drugs.
12. Services you receive from an out-of-network pharmacy, except as indicated in "Benefit Overview."

Preventive Care

Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, recommendations of the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control, the Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP) and Minnesota mandates. The frequency and eligibility of services is subject to change. For more information about preventive care services, go to bluecrossmn.com/preventivecare or call Customer Service at the telephone number on the back of your ID card.

<table>
<tr><th>The Plan Covers</th><th>In-Network Providers</th><th>Out-of-Network Providers</th></tr>
<tr><td>● Preventive physical examinations
● Immunizations
● Laboratory services for screening purposes
● Imaging services for screening purposes
● Hearing screening
● Routine vision screening from age 6 through age 18
● Colorectal cancer screening
● Screening gynecological examinations
● Papanicolaou test (Pap smear)
● Mammograms 2-dimensional (2-D) or 3-dimensional (3-D) for annual screening, including members with a previous history of breast cancer
● Prostate specific antigen (PSA) tests and digital rectal examinations
● Surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)</td><td>You pay nothing</td><td>You pay 50% coinsurance after deductible</td></tr>
<tr><td>Birth through age 5:
● Preventive physical examinations
● Developmental assessments
● Routine vision screening
● Laboratory services for screening purposes
● Imaging services for screening purposes
Birth through age 17:
● Immunizations</td><td colspan="2">You pay nothing</td></tr>
</table>

Preventive Care – Notes
1. Preventive examinations include a complete medical history, complete physical examination, as well as screening and counseling for obesity, depression, and tobacco cessation.
2. The plan covers the following screening services consistent with approved medical standards and practices for the detection of colon cancer when ordered by a physician: a. laboratory and pathology stool-based screening services b. imaging screening services such as barium enema or CT colonography c. surgical screening services such as flexible sigmoidoscopy, colonoscopy, and related services (e.g., sedation and pathology).

Preventive Care – Notes
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 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. 3. The plan covers: a. an initial physical examination to confirm pregnancy, b. folic acid supplement for members planning to become pregnant, c. counseling for contraceptive methods, d. counseling and support for breastfeeding, and e. the purchase of an electric or manual breast pump, or rental charges for a hospital-grade breast pump, and breast pump supplies. 4. The plan covers screening for sexually transmitted diseases and HIV at the in-network benefit. 5. The plan covers a range of FDA-approved preventive contraceptive methods for women with reproductive capacity. Benefits are provided for up to a 12-month supply for covered contraceptives, other than over-the-counter and emergency contraceptives, when prescribed by your provider for the prevention of pregnancy. Medical management may apply. Please also refer to "Prescription Drugs." 6. Please refer to "Hospital Inpatient Care, "Hospital Outpatient Care, "Office Visit and Professional Services," etc. when services are for: a. complications or an illness/injury diagnosed as a result of preventive care services b. preventive care services in excess of state and federal preventive recommendations and criteria. 7. The plan covers follow up diagnostic services or testing that your health care provider determines you require following your preventive mammogram.

Preventive Care – Not Covered
1. 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, including dental implants ● Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Reconstructive Surgery – Notes
1. If more than one 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 preoperative and postoperative care.
2. Congenital means present at birth.
3. 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.
4. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

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

Skilled Nursing Facility Care

The Plan Covers	In-Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational and speech therapy	You pay 20% coinsurance after deductible If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	You pay 50% coinsurance after deductible

Skilled Nursing Facility Care – Notes
1. 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 period of confinement unless the dates of discharge and readmission are separated by at least 90 days. 2. Skilled care ordered by a physician includes skilled care ordered by an advanced practice nurse or physician assistant when ordered within the scope of their licensure.

Skilled Nursing Facility Care – Not Covered
1. Custodial care. 2. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care. 3. Services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience.

Transplant

The Plan Covers	Blue Distinction Centers for Transplants(SM) (BDCT) Providers	Non-Blue Distinction Centers for Transplants (BDCT) Providers
• Bone marrow/stem cell • Heart • Heart-lung • Liver • Liver-kidney • Lung	You pay 20% coinsurance after deductible for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider If you receive services or a referral from Indian Health Services (IHS), American Indian tribes, tribal organizations, or Urban Indian Organizations, you pay nothing	Participating Transplant Provider: You pay 50% coinsurance after deductible Nonparticipating Transplant Provider: NO COVERAGE

Transplant – Notes
1. Prior authorization must be obtained before a transplant procedure. 2. BDCT facilities have a contract with the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to provide transplant procedures. These facilities have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Facilities are reevaluated regularly to ensure that they continue to meet the established criteria for participation in this network. 3. 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. 4. Participating transplant facilities have a contract with Blue Cross and Blue Shield of Minnesota or with their local Blue Cross and/or Blue Shield plan to provide transplant procedures. 5. The donor’s medical expenses directly related to the organ donation are covered under the recipient's plan. Treatment of any medical complications that occur to the donor are not covered under the recipient's plan. 6. Eligible transplants not performed in conjunction with a major transplant noted above are covered on the same basis as any other illness. Please refer to “Hospital Inpatient Care,” "Hospital Outpatient Care," “Office Visit and Professional Services.”

Transplant – Not Covered
1. Transplant services you receive from a nonparticipating provider. 2. Benefits for travel expenses when you are using a non-BDCT provider. 3. Travel expenses for an organ donor. 4. Services for or related to surgical implantation of nonhuman or mechanical devices that serve as a human organ are not covered. An exception is the surgical implantation of FDA-approved Ventricular Assist Devices (VAD) to serve as a temporary bridge to a heart transplant.

General Exclusions

Except as specifically provided in this health 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. Services which are not medically necessary based on the definition of "medically necessary and appropriate" in "Terms You Should Know."
2. Services which are experimental/investigative in nature, except for certain routine care for approved clinical trials.
3. Services that are prohibited by law or regulation.
4. Services rendered prior to your effective date of coverage.
5. Services incurred after the date of termination of your coverage.
6. Services for dependents if you have single coverage.
7. Services that are provided without charge, including services of the clergy.
8. Services rendered by a provider who is a member of your immediate family.
9. Services that are not within the scope of licensure or certification of a provider.
10. Services from providers who are not health care providers.
11. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay.
12. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
13. Blenderized food, baby food, regular shelf food when used with an enteral system, or banked breast milk.
14. Solid or liquid food, standard or specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except if administered by tube feeding or as provided in the “Medical Equipment and Supplies” benefit chart.
15. Infant formula with intact proteins.
16. Any formula (standard and specialized), when used for the convenience of you or your family members.
17. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
18. Any substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance.
19. Services for giving therapeutic drugs that can be self-administered.
20. Services for or related to self-administered drugs, except prescription drugs and products as stated in the “Prescription Drugs” section.
21. Services for or related to tobacco cessation, except tobacco cessation drugs and products as stated in the “Prescription Drugs” section.
22. Prescription drugs, including but not limited to biological products, biosimilars, and gene or cellular therapies, that have an alternative drug available similar in safety and effectiveness and is more cost-effective.
23. Services for or related to gene therapy or cellular therapy until they have been evaluated by Blue Plus and deemed eligible for coverage.
24. Charges for selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or health outcomes.
25. Investigative or non-FDA approved drugs, except as provided by law.
26. 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.

27. Bulk powders, chemicals, ingredients and products used in prescription drug compounding.
28. Intact protein/protein isolates, including but not limited to, semisynthetic, natural, plant-based, or hydrolyzed, when taken orally (for example, protein powders).
29. Services for or related to chelation therapy, except when medically necessary and appropriate.
30. Vitamins, dietary supplements, and over-the-counter (OTC) drugs, unless listed on the covered drug list and prescribed by a health care provider. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the member obtains a prescription for the item.
31. Services, testing, equipment, devices, technologies and supplies purchased or available over-the-counter, whether or not prescribed by a health care provider, unless listed on the covered drug list or covered under preventive care.
32. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
33. Any portion of a charge for a covered service or supply that exceeds the allowed amount.
34. Charges billed by an out-of-network provider for the completion of a claim form.
35. Services for furnishing medical records or reports and associated delivery services.
36. Charges for the covered patient’s failure to keep a scheduled visit.
37. 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.
38. Travel, transportation, or living expenses, whether or not recommended by a physician, except for travel expenses and ambulance transportation listed as covered in the benefit charts and “Benefit Overview.”
39. Services primarily educational in nature, except as provided herein.
40. Services for educational classes or programs, except for services such as nutritional education for anorexia nervosa, bulimia or eating disorders; parent education following early maternity discharge; prenatal education; diabetes out-patient self-management training and education; specialty drug patient education that cannot be provided by a retail pharmacy; and preventive patient education/counseling for women with reproductive capacity, or as otherwise required by law.
41. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
42. Maintenance services unless a part of a specialized therapy for the member's condition.
43. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
44. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; 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.
45. Services provided during an e-visit for the sole purpose of: scheduling appointments; reporting normal test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite office visit; and services that would similarly not be charged for an onsite office visit.
46. 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.
47. Services for or related to functional capacity evaluations for vocational purposes or the determination of disability or pension benefits.
48. Services for or related to the repair of scars and blemishes on skin surfaces.
49. Services for or related to fetal tissue transplantation.
50. Custodial care, nonskilled care, adult daycare or personal care attendants.
51. Room and board for outpatient services.

52. Services that are primarily for the convenience of the member, physician, or health care provider or are more costly than alternative services or sequence of services that are clinically appropriate and are likely to produce equivalent therapeutic or diagnostic results to treat a member's illness, injury, or disease.
53. Services, claims, or charges related to conversion therapy.
54. Physical examinations for the sole purpose of obtaining/maintaining employment, insurance, licensing, certification or physicals for school, camp, or sports.
55. Services for or related to care that can be provided by a non-skilled caregiver, who has been trained or is capable of being trained.
56. Services for respite care, except as described in "Hospice Care – Notes."
57. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community, including but not limited to, homeopathy, naturopathy, reiki.
58. 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; spas; etc., and all related material and products for these programs.
59. Services for or related to therapeutic massage.
60. Services for or related to acupuncture, except when medically necessary and appropriate (the exceptions are limited to 20 visits per person per calendar year for all networks combined).
61. Services for hippotherapy (equine movement therapy).
62. Services for or related to bariatric surgery.
63. Services and prescription drugs for or related to assisted reproduction.

Health Care Management

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. Blue Plus' review includes applying medical criteria that may require a provider to submit a treatment plan. All applicable terms and conditions of your plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, admission notification, or emergency admission notification.

Prior authorization and admission notification are required for specific services.

If the care you receive is due to a medical emergency, prior authorization is not 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 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. Prior authorization should be obtained before a service is rendered and, if applicable, before additional services are rendered beyond what has previously been approved. 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 and behavioral health policies. 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 bluecrossmn.com/priorauth or call Customer Service at the telephone number on the back of your ID card.

A continued stay review (inpatient) or extension request (outpatient) is a process that involves review of an ongoing service for a member with an existing authorization or an admission notification for acute hospitalization. It includes determining whether the current health care facility is still the most appropriate to provide the level of care required for the patient, or whether continued care is medically necessary. These types of review may also be referred to as "concurrent review."

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, 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. **Call Customer Service at the telephone number on the back of your 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 six business days prior to scheduling the care/services to determine if the services are eligible. We will notify you of our decision within five business days after receiving the request, 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 the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. See "Complaint and 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. **Call Customer Service at the telephone number on the back of your 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, inform us that you will be admitted for inpatient hospitalization or post-acute care services, separate from prior authorization. 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 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 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 on the back of your ID card.

Note: If at the point the claim is processed, it is found that any services received from a nonparticipating provider were not medically necessary, 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 six business days prior to services.	Provider is responsible for completing the notification at least 72 hours prior to the admission or as soon as reasonably possible, no later than two business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two 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 six business 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 business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two business days, following the admission.

Services received from:	Prior Authorization	Admission Notification	Emergency Admission Notification
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least six business days prior to services.	You are responsible for completing the notification and you must call at least 72 hours prior to the admission, or as soon as reasonably possible, no later than two 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 business days, following the admission.

Medical and Behavioral Health Policy Committee and 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 and Behavioral Health Policy Committee, which consists of independent community physicians who represent a variety of specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, 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 policies may be created, or existing policies may change. Covered benefits will be determined in accordance with the policies in effect at the time treatment is rendered or, if applicable, prior authorization may be required. Internally developed medical policies can be found at bluecrossmn.com/priorauth. All medical and behavioral health policies are available upon request.

How Your Program Works

Your Provider Network

Choosing a Health Care Provider

You and your covered dependents may choose any eligible provider of health services for the care you need.

When you choose in-network providers, you generally get the most benefits for the least expense and paperwork. You present your member ID card to the in-network provider who submits your claim to Blue Plus.

Not every provider is an in-network provider for every plan. Log in at bluecrossmn.com or call Customer Service at the telephone number on the back of your ID card to:

- find an in-network provider,
- use our cost calculator,
- view board certification information, hospital affiliation, or other professional qualifications of your provider

In-Network Pharmacies

Retail Pharmacy: Participating retail pharmacies have an arrangement with Blue Plus to provide prescription drugs to you at an agreed upon price.

90dayRx: You may use a 90dayRx participating retail pharmacy and/or a mail service pharmacy to fill your prescriptions. These options offer savings and convenience for prescriptions you may take on an ongoing, long-term basis.

Specialty Pharmacy Network Supplier: The specialty pharmacy network supplier has an agreement, with Blue Plus for the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

In-Network Care

In-network providers have a contract with Blue Plus. Your provider network is determined by your specific health plan.

In-network providers are providers in the Blue Plus Minnesota Value network.

In-network providers make it easier for you to get care. In-network providers 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.

Getting your care "through the in-network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the in-network. We consider educational background, board certification and performance history to determine eligibility. Then we monitor care on an ongoing basis through our credentialing department, which may include office record reviews and member satisfaction surveys.

In-network providers include a wide range of specialists; mental health and substance use disorder providers; community and specialty hospitals; pharmacies, and laboratories in the plan service area.

You and your covered dependents are each encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist if the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Your online provider directory lists in-network providers in our service area and may change from time to time, at least once a month, to reflect any changes in our network. Prior to receiving services, it is recommended that you verify your provider’s network status with Blue Plus, including whether the provider is an in-network provider for your particular plan. If you have questions regarding you provider network, we will respond within one business day of your inquiry.

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.

Out-of-Network Care

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

When you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. You will likely pay more for your care compared to what you pay when seeing an in-network provider.

Out-of-Network Participating Providers

Out of network participating providers are providers who have a contract with us or with another Blue Cross and/or Blue Shield plan but are not in-network for your specific plan.

Out of network participating providers may obtain prior authorization, admission notification, and emergency admission notification for you (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 are not in-network and do not have a contract with us or another local Blue Cross and/or Blue Shield plan.

If you receive care from a nonparticipating provider, 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 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. Benefit payments are calculated on Blue Plus' allowed amount, which is typically lower than the amount billed by the provider.

If you receive services from a nonparticipating provider, you will be responsible for any deductibles, copay, 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.

Participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

Out-of-Area Care

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

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

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

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

If you are temporarily away from home (e.g., vacation) and need to refill a prescription, call Customer Service for help. They can help you find an in-network pharmacy near the area you are visiting. You can also use the member website to find a pharmacy. Once you have the name and address of the in-network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process.

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.

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 Plus 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 prior approval for non-emergency inpatient services.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Plus, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven 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 non-emergency services will be processed at the out-of-network level of benefits.

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

Continuity of Care

A current member or dependent with Blue Plus may request to continue current care when:

- 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 not for cause, and
- You want to continue to receive care for a special medical need or condition for a reasonable period of time before transferring to a participating provider as required under the terms of your coverage 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 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 a current member undergoing treatment within the first trimester of pregnancy;
6. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
7. are receiving services from a provider that speaks a language other than English.

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

Limitation

Continuity of care applies only if your provider agrees to:

- accept Blue Plus' allowed amount;
- adhere to all Blue Plus prior authorization requirements; and
- 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.

Transition to In-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.

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.

Continuity of Care - Transition of Prior Authorization

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

Whom We Pay

When you or your dependents use a participating provider for covered services, we pay the provider. When you or your dependents use a nonparticipating provider either inside or outside the state of Minnesota for covered services, we pay you, except as described in “Special Circumstances.”

You may not assign your benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that we 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 contract. This provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and certain out-of-state institutional and medical/surgical providers.

You also may not assign your right, if any, to commence legal proceedings against Blue Plus.

In the event of loss of life, if you used a nonparticipating provider, we will pay for covered services in accordance with the beneficiary designation and the provisions respecting such payment that may be effective at the time of payment.

If no such designation or provision is then effective, such indemnity shall be payable to your estate. Any other outstanding payments for covered services unpaid at the time of your death may, at your option, be paid either to such beneficiary or to such estate. All other payments for covered services will be payable to you.

Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to you. The consent of the beneficiary is not required to surrender or assign benefits under this benefit booklet or to change the beneficiary or make other changes in this benefit booklet.

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.

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, except as described in “Special Circumstances.” This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. 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.

Provider Payment Arrangements

This 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.

Participating Providers

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

The allowed amount may not include other payment adjustments which may occur periodically including settlements to capture complex claims accurately, settlements for withhold, capitation, outlier cases, fee schedule adjustments, rebates, prospective payments or other methods. Such adjustments are completed without reprocessing individual claims. These settlements will not cause any change in the amount members paid at the time of claims processing. If the payment to the

provider is decreased, the amount of the decrease is credited to us, and if the payment to the provider is increased, we pay that cost.

General Provider Payment Methods

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.

Depending upon your health plan, a participating provider may be an in-network provider or may be an out-of-network participating provider. Payment will be based upon which network the participating provider is in for your health plan. Please refer to "How Your Program Works" for additional detail on covered services received in the in-network and out-of-network.

1. Professional (i.e., doctor visits, office visits)

   Fee for Service or Discounted Fee for Service. Providers are paid for each service or bundle of services. Payment is based on a fee schedule allowance for each service or a percentage of the provider's billed charge.

   Withhold and Bonus Payments. Providers are paid based upon a fee schedule or percentage of billed charges, and a portion is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the care while demonstrating the optimal treatment for patients.

   Capitation Payments. Providers may be paid in part based upon a per member per month capitation amount. This amount is calculated based upon historical costs and volumes to determine the average costs for providing medically necessary care to a patient.

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

   Inpatient Care

   - Payments for each case (case rate) or for each day (per diem). Providers are paid a fixed amount based upon the member's diagnosis at the time of admission in a hospital or facility.
   - Percentage of Billed Charges. Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient services.
   - DRG Payments. All Patient Refined Diagnosis Related Groups (APR DRG) or other DRG payments apply to most inpatient claims. DRG payments are based upon the full range of services the patient typically receives to treat the condition.

   Outpatient Care

   - Enhanced Ambulatory Patient Groupings (EAPG) is used for payment on most outpatient claims. EAPG payments are based upon the full range of services the patient typically receives to treat the condition.
   - Payments for each Category of Services. Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one or more related visits.
   - Payments for each Visit. Providers are paid a fixed or bundled amount for all related services a member receives during one visit.
   - Percentage of Billed Charges. Providers are paid a percentage of their regular billed charges for services.

3. Special Incentive Payments

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

4. Pharmacy Payment

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

   - Average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
   - Pharmacy's retail price

- Maximum allowable cost we determine by comparing market prices (for generic drugs only); or,
- Pharmacy's billed charge.

Nonparticipating Providers

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

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

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

Example

The following illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health plan covers 80% for participating providers and 60% for nonparticipating providers.

	Participating Provider	Nonparticipating Provider
Provider Charge:	$150	$150
Allowed Amount:	$100	$80
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

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

Your Rights and Protections Against Surprise Medical Bills

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

Balance billing is prohibited when you get emergency care or are treated by a nonparticipating provider at an in-network hospital or ambulatory surgical center. In-network cost sharing for these services must be applied to your in-network deductible/out-of-pocket maximum.

When a claim is identified as a special circumstance, payment will be made to the nonparticipating provider when required by law. These nonparticipating providers can negotiate with Blue Plus for a higher allowed amount after the initial payment has been made. This may result in an increase to the amount applied to your in-network cost-sharing. For additional information, visit bluecrossmn.com/nosurprises.

You are protected from balance billing for:

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

Steps You Can Take

If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the services, this could be a "surprise" or "balance" bill. If you have questions regarding what a "surprise" or "balance" bill is, call Customer Service at the number on the back of your ID card or visit bluecrossmn.com/nosurprises. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law, please refer to "Emergency Care" for coverage of benefits. You may appeal a decision that your claim does not qualify as a special circumstance. Please refer to "Complaint and Appeal Process."

Who is Eligible for Coverage

Eligible Dependents

Your Spouse

Your spouse is:

The person to whom you are legally married.

Your domestic partner. A domestic partner is an adult whom you are in a committed and mutually exclusive relationship with and with whom you are jointly responsible for each other's welfare and financial obligations.

Your partner must:

- Be at least 18 years of age and unmarried,
- Be mentally competent,
- Not be your blood relative, and
- Resides with you in the same principal residence and intends to do so permanently

Your Dependent Children

Dependent children up to the limiting age of 26 includes:

- Your children
- Your stepchildren
- Children of your domestic partner
- Children legally placed for adoption
- Children for whom you or your spouse have been appointed legal guardian
- Foster children
- Grandchildren who live with you or your spouse continuously from birth and are financially dependent upon you or your spouse
- Children awarded coverage because of a court order
- Disabled dependent over the limiting age who is not able to support themselves because of developmental disability, mental illness or disorder, or physical disability; and, primarily dependent upon the contractholder for support and maintenance. See section "Adding a Disabled Dependent."

A dependent child's coverage automatically terminates, and all benefits hereunder cease at the end of the plan year the dependent reaches the limiting age or ceases to be a dependent as indicated above, whether notice to terminate is received by Blue Plus.

Enrollment and Effective Dates

Coverage starts on the date specified in the lower right-hand corner of the front cover. This is the effective date for you and any eligible dependents who enroll on or before that date.

Monthly premiums must be paid from the date coverage starts.

Adding New Dependents

Dependents may be added during the initial open enrollment period and subsequent annual open enrollment periods, and in the special enrollment situations outlined below.

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

Adding a Disabled Dependent

Once a covered child dependent reaches the limiting age, you may apply to continue coverage for the dependent as a disabled dependent.

To be eligible for coverage, the child must meet the disabled dependent criteria in the "Your Dependent Children" section above and be enrolled in your plan prior to reaching the limiting age.

We require proof of eligibility and we may request proof of eligibility again two years later, and each year thereafter.

Your request must be made within 31 days from when the child reaches the limiting age.

Special Enrollment Periods

Special enrollment periods are periods when you and your eligible dependent(s) may enroll in a new or make changes to an existing health plan when all enrollment conditions are met.

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.

Special Enrollment Qualifying Life Events

Losing health coverage that is not minimum essential coverage is not considered a loss of minimum essential coverage. Voluntarily quitting other health coverage or loss of coverage due to failure to pay premiums or rescission do not qualify as special enrollment events.

The coverage effective date cannot be prior to the occurrence of the event.

Eligible Circumstances	You or your dependent can request coverage	Special Instructions
New dependent	for the dependent because of: ● 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 ● placement for adoption or foster care ● court order	
Permanent move	due to 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
Loss of existing minimum essential coverage	when they are no longer covered under a health plan with minimum essential coverage because: ● employer no longer offers benefits or employer closes ● loss of eligibility for employer-sponsored coverage due to job loss or reduction in hours ● termination of all employer contributions ● death of primary contractholder ● primary contractholder becomes entitled to Medicare ● legal separation or divorce from primary contractholder ● loss of dependent child status	

Eligible Circumstances	You or your dependent can request coverage	Special Instructions
	● move outside existing ACO or HMO service area ● expiration of COBRA or non-calendar year policy or employer stops paying premiums	
Loss of eligibility for Medicaid, MinnesotaCare or CHIP	when they have been covered under Medicaid, MinnesotaCare or CHIP at the time coverage was effective and lose eligibility	This includes loss of pregnancy related or medically needy coverage under Medicaid
Eligibility for Advance Premium Tax Credit (APTC)* or Cost-sharing Reductions (CSR) *APTC is only available through MNsure	when there is a change in income, household or other status that affects eligibility	Must currently be enrolled in a Qualified Health Plan, or ● have had medical essential coverage within the prior 60 days
Newly eligible for Advanced Premium Tax Credit (APTC)* *APTC is only available through MNsure	new eligibility for Advanced Premium Tax Credit (APTC)* due to not being eligible for coverage by an eligible employer sponsored plan	Notification can be 60 days prior to and 60 days after the loss of coverage
Enrollment error or material misrepresentation	when MNsure or the health plan determines ● an unintentional enrollment error is the result of an action or omission by an agent of MNsure or non-exchange entity ● 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	
Untimely notice of triggering special enrollment	when the notice of eligibility for a qualifying event is not timely and the qualified individual did not know about their triggering event	● Notification can be 60 days from the notice of the special enrollment Must have documentation confirming the untimely notice
Individual Coverage Health Reimbursement Arrangement (ICHRA) and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	when they gain access to an individual health reimbursement account or are provided a qualified small employer health reimbursement account	

Additional Eligible Circumstances

An individual who 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 American 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 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.

Cancellation of This Contract

During the course of your coverage or a continuation period, if your marital status changes or a dependent is no longer an eligible dependent under the terms of this contract, you or your dependent must notify us in writing. In addition, you must notify us in writing if a disabled dependent is no longer disabled.

You must provide notification within 60 days of changes in you or your dependent's eligibility to obtain continuation of coverage options. Refer to the "Continuation of Coverage" for information regarding extension of coverage.

If you or your dependents do not provide this required notice, any dependent who loses coverage is NOT eligible to elect continuation coverage. Furthermore, if you or your dependent do not provide this required notice, you and your dependent must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

If we cancel this contract, coverage will be canceled for the contractholder and all covered dependents. We refund any unearned premiums in the event of cancellation of this contract.

Cancellation Reasons

We have the right to cancel, decline to issue, or fail to renew this contract, including retroactively, if any of the following occurs:

- Required premiums are not paid when due.
- You fail to complete and return information requested by Blue Plus in connection with confirming your eligibility.
- You move out of the plan's network service area. We will give you 90 days advance notice before the cancellation.
- You perform an act that constitutes fraud or intentional misrepresentation of a material fact.
- We cease doing business in the individual health plan market. We will give you 180 days advance notice before the cancellation.

We will give you 30 days advance notice before the retroactive termination (retroactive termination is also called "rescission").

Contractholder Request to Cancel

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.

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 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.

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 plan if coverage ends because of any of the qualifying events listed below.

A spouse and or dependent children not covered at the time of the contractholder's death is not eligible to elect continuation coverage.

In all cases, continuation ends in the event this health 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: ● Enrollment Date in other group coverage ● 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: ● 36 months ● Enrollment Date in other group coverage ● Date coverage would otherwise end
Dependent child loses eligibility	Dependent child	Earliest of: ● 36 months ● Enrollment Date in other group coverage ● Date coverage would otherwise end
Contractholder only cancels coverage	All dependents	Date coverage would otherwise end

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.

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, call Customer Service at the telephone number on the back of your ID card.

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.

Coordination of Benefits

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

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

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

Definitions

These definitions apply only to this section.

Plan - Any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. 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;
2. Coverage under a government plan or one required or provided by law; or
3. Individual coverage.

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

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

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

This Plan - This individual health plan that provides health care benefits.

Primary Plan/Secondary Plan - The "Order of Benefits Rules" establish whether this plan is the primary plan or secondary plan when compared to the other plan covering the member.

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 plans, this plan may be a primary plan as to some plans and may be a secondary plan as to other plans.

Allowable Expense - The necessary, reasonable, and customary item of expense for health care, covered at least in part by one 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.

Claim Determination Period - 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

Blue Plus uses the following rules to establish which plan is the primary plan:

You and Your Dependents

1. When your other plan does not include order of benefit rules, then that plan is the primary plan.
2. The plan that covers the member as a contractholder is the primary plan over the plan that covers the member as a dependent.

Dependent Children

1. Birthday Rule

    a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
    b. If both parents have the same birthday, the plan that covered the parent longer will be the primary plan.

2. Separated or Divorced Parents

    a. The plan of the parent with custody of the child is the primary plan.
    b. The plan of the spouse of the parent with custody is the secondary plan.
    c. When a court decree specifies the parent who is financially responsible for the child's health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of that parent is the primary plan. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

Other

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

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

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

Effect on Benefits of This Health Plan

When the "Order of Benefits Rules" establish that this health plan is a secondary plan, benefits of this health plan may be reduced. Combined benefit payments will not exceed the total allowable expense. This applies whether or not a claim is made under a plan.

Reduction in this plan's benefits is equal to the difference between:

1. The benefit payments this plan would have paid had it been the primary plan; and
2. The benefit payments that this plan actually paid or provided as the secondary plan.

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

Reimbursement and Subrogation

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

If we pay benefits for covered services you incur as a result of any act of any person, and you later obtain full compensation, you or your dependents, heirs, guardians, executors, trustees, or other representatives are obligated to reimburse us for the benefits paid. If you or your dependents receive benefits under this health plan arising out of illness or injury for which a responsible party is or may be liable, 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.

What May Happen to Your Future Benefits

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

Worker's Compensation

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

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 enrollment with Blue Plus 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.

Facility of Payment and Right of Recovery

When another plan pays an amount that should have been paid under this plan, 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.

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.

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

Claims Process

In-network providers file your claims for you. If you use an out-of-network provider, you may have to file the claim yourself.

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

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.

Authorized Representatives

You have the right to appoint an authorized representative to file or pursue a request for reimbursement or other post-service claim, complaint, or appeal on your behalf. You may be required to sign an authorization to appoint an individual to act on your behalf.

Prescription Claims

When you purchase covered prescription drugs from a pharmacy in the network applicable to your health plan, present your prescription and your member ID card to the pharmacist. Prescriptions that the pharmacy receives by telephone from your physician or dentist may also be covered. You should request and retain a receipt for any amounts you have paid for income tax or any other purpose.

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 for 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. You will also be required to file a claim. Please refer to "How to File a Claim."

To use a 90dayRx participating retail pharmacy, verify that your pharmacy participates in the network and present your prescription for a 93-day fill of the eligible prescription medication.

For more information on how to use a mail service pharmacy, log in at bluecrossmn.com or call Customer Service at the telephone number on the back of your ID card.

Requests for Drugs Not Covered by this Plan

You may request an exception when your prescribing health care professional believes that you need coverage for a clinically appropriate drug that is not covered by this plan. You, your authorized representative, or the prescribing health care professional must submit an exception request to Blue Plus. If an exception is granted for a non-covered specialty drug, it will be covered under the designated prescription specialty drug tier.

Standard Exception Request

We will review standard requests and notify you and your 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

An expedited review applies when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are 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 you and your prescribing health care provider of our determination within 24 hours of receiving the request.

Independent Review Organization (IRO)

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

You and your 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, within 24 hours of receiving the request for external review.

If an exception request is approved, whether upon our initial determination or following external review by the IRO, coverage will be provided as follows:

- for approved standard requests, coverage will be provided for the duration of the prescription;
- for approved expedited requests based on exigent circumstances, coverage will be provided for the duration of the exigency.

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

How to File a Claim

You may request that we send you a claim form. 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 available at bluecrossmn.com or by calling Customer Service at the telephone number on the back of your ID card.

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. However, we waive these limits 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 notice of the decision on your claim with 30 business days after we receive the claim and any other required information.

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

Your Explanation of Health Care Benefits (EOB)

An EOB is not a bill. Instead, it explains how your benefits have been applied. It shows what you may owe your provider after your health insurance claim has been processed. You should review it to make sure you received the services that are being billed and that the amount being billed matches the amount shown on the EOB.

When you or your provider submit a claim, you will receive an EOB statement that lists:

- The provider's actual charge;
- The allowed amount as determined by Blue Plus;
- The copay; deductible, and coinsurance amounts, if any, that you are required to pay;
- Total benefits payable; and
- The total amount you owe.

You will receive an EOB only when you are required to pay amounts other than your required copay. You may view your EOBs for all claims when you log in at bluecrossmn.com. If you do not have access to a computer or prefer to continue receiving printed EOBs, call Customer Service at the telephone number on the back of your ID card.

Complaint and Appeal Process

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

How to Voice a Complaint

You or your authorized representative may call us to complain or appeal any aspect of your health care benefits. This includes concerns relating to in-network providers, coverage, operations or management policies. Call Customer Service at the telephone number on the back of your ID card.

A representative will review, research, and respond to your inquiry 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 receipt, you may submit a written complaint or written first level appeal.

We will provide you or your authorized representative a form to include all necessary information to file your written complaint or appeal. If you need assistance, we will complete the form and mail it to you for your signature. The form to file a complaint or appeal is also on our website.

Mail the completed form to the address listed below. Please include your identification and group numbers as displayed on your member ID card.

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 982900
Attention: Appeals and Grievances
El Paso, TX 79998

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

Fraud or Provider Abuse

If you think that a provider is committing fraud, please let us know. Examples of fraud include: submitting claims for services that you did not get; adding extra charges for services that you did not get; giving you treatment or services you did not need. You may also call the local state Fraud Hotline.

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 any of the following methods:

- Visit www.mnsure.org and log into your account.
- Call the contact center 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.

Written Complaints and First Level Appeals

Your appeal should tell us all reasons and provide all evidence in support of your complaint or appeal unless that evidence is already in our possession.

The request for a first or 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 and/or denied claim
- 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 within 10 business days that we have received your written complaint or appeal.

Blue Plus has two 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. You are required to submit a first level appeal before you

can exercise any other rights to appeal or other 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.

Written Complaints and First Level Appeals that do not Require a Medical Determination

We will inform you of our decision and the reasons for the decision within 30 days of receiving your complaint or 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 request copies of the information that we relied on during this review.

First Level Appeals that Require a Medical Determination

The "Health Care Management" section explains the prior authorization and admission notification processes. If we deny your request for benefits through one of these processes or you receive a claim denial, the denial will describe the process for initiating an appeal. You or your attending health care provider may appeal Blue Plus' initial determination to not authorize services in writing or by telephone.

You or your authorized representative may appeal after services have been provided when a decision is wholly or partially adverse to you.

The decision on the first level appeal will be made by a medical reviewer who did not make the initial determination. You have the right to request copies of information relied on in making the initial determination.

Standard First Level Appeal

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 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.

Expedited First Level Appeal

When Blue Plus' initial determination to not authorize 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. Our appeal staff will engage 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 your 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, you will be notified of your right to submit the appeal according to the external review process described below.

Second Level Appeal

You may appeal our final decision through External Review. Alternatively, you may voluntarily appeal to our internal appeals committee 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 on which to include all the information necessary for your 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.

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 denial notice will advise you of how to submit the decision to External Review as described below. Upon request, we will provide you a complete summary of the appeal decision.

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 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 appeal options 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 applied for an Expedited External Review at the same time.

You or anyone you authorize to act on your behalf may submit the appeal to External Review. You must request External Review within six 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 at the address below along with a $25 filing fee. You will not be subject to filing fees totaling more than $75 per policy year. The Commissioner may waive the fee in cases of financial hardship. Blue Plus will refund the fee if our determination is reversed by the external reviewer.

Minnesota Department of Health
Attention: Managed Care Systems Section
P.O. BOX 64975
St. Paul, MN 55101-2198

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 must make its expedited determination to uphold or reverse the adverse benefit determination as expeditiously as possible, but no more than 72 hours after receipt of the request for expedited review and notify you and Blue Plus of the determination.

The external review entity's decision is binding on Blue Plus, but not binding on you.

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 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 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 plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this health plan found in "Claims Process." No legal action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Grace Period

If you are receiving advance premium tax credit (APTC) payments, we allow a 3-month grace period. The first grace period month starts on the day after the 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 three-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 three-month grace period, your health plan lapses retroactively to the date to which coverage has been paid. You are responsible for any claims incurred after the termination date.

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 premium tax credit (APTC) payment, we allow a 31-day grace period for payment. The grace period starts on the day after the 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 plan lapses retroactively to the date to which coverage has been paid. You are responsible for any claims incurred after the termination date.

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.

You can request for your contract to be reinstated in writing, over the phone or by sending all required premium(s) to pay you to the current month. Your request must be received within 63 calendar days from your termination date.

If approved, your contract will be reinstated as of the date your contract was terminated. Coverage will be reinstated for the contractholder and all covered dependents. All required premium(s) must be received and you must be paid to the current month to be reinstated.

If your request is not approved, we will notify you in writing of our decision. A refund will be processed separately, if applicable.

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. Native nations, tribal organizations, and Urban Indian Organizations;
4. Small employers that qualify as a Qualified Employer Health 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. For a QSEHRA or ICHRA arrangement, the employer or third-party administrator (TPA) may request to update billing related information (e.g. address to send invoice) on the account to ensure smooth payment processing. If the billing address is updated to the employer or TPA, you will no longer receive paper invoices, past due premium notices, or cancellations notices. The employer or TPA will be responsible for sharing those notices with you. Blue Plus needs to be notified if you change employers or TPA.

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, call Customer Service at the telephone number on the back of your 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.

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. We will provide the good faith estimate within 10 business days of receiving all information necessary to provide the estimate.

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 relating to in-network provider, out-of-network participating provider or nonparticipating provider services. Claim reprocessing may result in changes to the amount paid at the time your claim was originally processed.

Liability for Health Care Expenses

Blue Plus welcomes the use of drug manufacturer coupons to help pay the cost of drugs. However, only the amount you pay out-of-pocket for your 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 drug purchase.

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 "Questions?"

NOTE: You'll get this notice each year. You will also get 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.

F**or 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 **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 **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).

Medicare End Stage Renal Disease Program Registration

For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and Blue Plus. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.

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.

Terms You Should Know

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

90dayRx - Participating 90dayRx mail service and retail pharmacies used for the dispensing of a 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 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.).

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

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 "Benefit Overview." The allowed amount may include the provider's applicable taxes, for example, the MinnesotaCare Tax.

The Allowed Amount for Participating Providers

For participating providers, the allowed amount is the negotiated amount of payment that the 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, which may include an agreed upon fee schedule rate, case rate, withhold and or/capitation agreements, rebates, prospective payments or other methods, we may adjust the amount due to 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 in "Special Circumstances," 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 of billed charges; (3) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (4) as may be required by federal law.

The payment option selected by Blue Plus 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 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 in “Special Circumstances,” 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 of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; (4) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (5) as may be required by federal law. The payment option selected by Blue Plus may result in an allowed amount that is a lower amount then if calculated by another payment option. When the Medicare 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.

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.

Appeal - Any grievance that is not the subject of litigation concerning any aspect of the provision of health services under this benefit 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 individual 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 for appeals that require a medical determination.

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

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 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 made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cellular therapies, and vaccines.

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

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use 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.

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

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 Cross).

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

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 as determined by us.

Covered Drug List - The designated covered drug list for this plan 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. For a list of drugs on your covered drug list log in at bluecrossmn.com or call Customer Service at the telephone number on the back of your ID card.

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 hours per day, three to five days per week.

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary in-network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount. The dollar amount reimbursed or paid by a coupon will not count toward your deductible.

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

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

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

Durable Medical Equipment - Medical equipment prescribed by a physician that meets each of the following requirements:

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

5. represents the most cost-effective alternative.

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.

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.

Extended Hours Skilled Nursing Care (Private Duty Nursing) - Extended hours home care are continuous and complex skilled nursing services greater than two 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.

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 orthoses is manufactured in quantity and not designed for a specific member. A custom-fitted orthosis is specifically made for an individual member.

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.

Gender affirming care - Medical, surgical, counseling, or referral services, including telehealth services, legal under Minnesota State Law, that an individual may receive to support and affirm that individual's gender identity or gender expression.

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

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 Provider - 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 dietitians, 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 preapproved facility that sends health care professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals diagnosed with a terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (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 licensee, outside of Minnesota, that has contractual relationships with providers in its designated service area that delivers the benefit of its arrangements with its local and ancillary providers eligible for Inter-Plan Programs, on behalf of Control/Home Licensee members who incur claims within its service area.

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

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

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

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

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 a home delivery option.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time.

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

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

Medical Emergency - Medically necessary and appropriate care which a reasonable 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 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 - A provider who has 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 licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders.

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

Palliative Care - Services specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services are focused on improving quality of life by enabling a patient to address social, emotional and spiritual needs, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Partial Programs - An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five to six hours per day, five 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 their license.

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

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

Prescription Drugs - Drugs that are required by federal law to be dispensed only by prescription of a health care provider 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.

Rare Disease - a disease or condition that:

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

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

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

Rescission - A cancellation or discontinuation of coverage 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 licensed under state law in the state in which it is located that provides residential treatment under the direction of a licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders. The facility provides continuous, 24-hour supervision by skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day.

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

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

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

Self-Administered Drugs - Drugs you would normally take on your own. 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, including specialty drugs.

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

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care, by or under the direction of a Doctor of Medicine (M.D.) or osteopathy (D.O.). 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 their illness, treatment, and the requirements of everyday independent living.

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

Step Therapy - Step therapy includes, but is not limited to, drugs in specific categories or drug classes. If your health care provider prescribes one of these drugs, there must be documented evidence that you have tried another eligible drug(s) that is safe, more clinically effective, and in some cases more cost effective before the drugs subject to step therapy will be paid under the drug benefit. Step therapy protocol does not apply to stage four advanced metastatic cancer or associated conditions in accordance with Minnesota law.

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, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health 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.

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

1. ostomy supplies,

2. catheters,
3. oxygen, and
4. diabetic supplies.

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

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

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

Terminally Ill Patient - An individual who has a life expectancy of six 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 day a week for a minimum two-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 drugs 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 illness or injury. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.

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

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
3300 Wells Fargo Center
90 South 7th Street
Minneapolis, Minnesota 55402
Telephone: (612) 322 8713
Fax: (402) 474 5393
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.

Blue Cross and Blue Shield of Minnesota and Blue Plus

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

BlueCross BlueShield Minnesota

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 and 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 and 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

BlueCross BlueShield Minnesota

Effective April 24, 2023

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"), or information about race, ethnicity, gender, gender identity, sexual orientation or language, 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
- 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
   3400 Yankee Doodle Road P-32
   Eagan, MN 55121

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

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