Group Vision Benefit Booklet

For Employees of:
State of Minnesota

2024 State Employee Group Insurance Plan Eyewear Only

Notice of Nondiscrimination Practices

Effective July 18, 2016

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

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

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

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

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

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

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

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

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

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

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, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလီတဖဉ်နွဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ်, ကိး 711 တက့်.

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.

Questions?

Call Us

Our customer service staff is available to answer your questions.

Interpreter services are available to assist you. This includes spoken language and hearing interpreters.

Hours are Monday through Friday: 7:00 a.m.- 8:00 p.m. United States Central Time.

Hours are subject to change without prior notice.

Customer Service Telephone Number	For claims and benefit inquiries call 1-888-921-1192. For all other inquiries such as member ID Cards, call 1-866-873-5943.
Interpreter Services	See Section “Language Access Services” on page 2.
Blue Cross and Blue Shield of Minnesota Website	www.bluecrossmn.com
Mailing Address	Claims review requests and inquires may be mailed to the address below: Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110

IMPORTANT! We issue each group member an identification (ID) card. If any of the information on your member ID card is not correct, please contact us immediately. When receiving care, present your member ID card to the vision care provider who is rendering the services.

A copy of our privacy procedures is available on our website at www.bluecrossmn.com or by calling Customer Service at 1-800-382-2000.

Table of Contents

Welcome to Blue Cross

On behalf of Blue Cross, we are pleased to welcome you as a member.

This is your vision plan member benefit booklet.

In this benefit booklet, "you" or “your" refers to the group member named on the identification (ID) card and other covered dependents. “We,” “us,” or “our” refers to Blue Cross.

Your vision plan, eligibility, notification procedures, and services/expenses that are covered and not covered are explained within this benefit booklet.

It is important that you read the entire benefit booklet carefully. It provides you with the information you need to understand your Blue Cross vision plan.

Blue Cross is the insurer and the claims administrator. This vision plan is considered fully insured. Coverage is subject to all terms and conditions of this benefit booklet, including medical necessity and appropriateness.

If you have questions about your coverage, please call our customer service at the telephone number listed on the back of your member ID card or visit one of our customer service locations listed in section “Questions?.”

You can also log onto your Blue Cross member website at www.bluecrossmn.com.

Thank you for choosing Blue Cross.

Your Benefits

This benefit booklet outlines the vision coverage under this plan.

To understand your benefits, read sections “Covered Services,” “Schedule of Benefits,” and “Services that are not Covered.” The “Terms You Should Know” section provides additional information on terms and conditions used in this benefit booklet.

Vision care providers are not beneficiaries under this benefit booklet.

All coverage of benefits for dependents and all references to dependents in this benefit booklet are not applicable for group member only coverage.

Covered Services

Benefits, any applicable copays, and allowances are shown on the “Schedule of Benefits.”

This benefit booklet provides coverage of benefits for a pre-determined schedule of vision services. Although other vision services may be recommended, they may not be covered under this benefit booklet.

Prior Authorization

We review all services to verify that they are medically necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your plan including exclusions, allowances, copays, and coinsurance provisions continue to apply with an approved prior authorization.

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered. Prior authorization for visually required contact lenses or eyeglasses and subsequent follow-up visits following such evaluation is required.

Participating providers are required to obtain prior authorization for you.

You are also required to obtain prior authorization when you use nonparticipating providers.

Some nonparticipating providers may obtain prior authorization for you. Verify with your nonparticipating providers if this is a service they will perform for you.

We will notify you of our decision within five working days after receiving the request, provided that the prior authorization request contains all the information needed to review the service.

We will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify you as expeditiously as the medical condition requires, but no later than 48 hours from receipt of the initial request or the end of the first business day after receipt of the initial request, whichever comes later, unless more information is needed to determine whether the requested benefits are covered.

Your actual coverage of benefits, including a final determination on coverage and payment, will be processed based on the claim submitted and your eligibility and benefit booklet at the time the vision service is performed and submitted.

Schedule of Benefits

This benefit booklet provides benefits for vision care only. It does not pay benefits for any other type of loss. As outlined within the benefit booklet, this plan only provides benefits for eyewear materials. It does not provide coverage of benefits for eye examinations.

Services shown on the "Schedule of Benefits" as covered are subject to any applicable frequency or age limitations as listed below.

Participating Provider (In-Network) Benefits	
Frequency for Services & Materials	**One Every**
Frame	Calendar Year
Eyeglass Lenses	Calendar Year
Contact Lens Evaluation, Fitting & Follow-Up Care (instead of eyeglasses)	Calendar Year
Contact Lenses (instead of eyeglasses)	Calendar Year

Participating Provider (In-Network) Benefits	
Service	**Copay** You pay
Retinal Imaging	$39

Participating Provider (In-Network) Benefits		
Eyeglass Benefit – Frame	**Allowance** The Plan pays up to	**Discount** On remaining costs
Frame Allowance (Retail) ● Discount does not apply at Walmart, Sam's Club, Costco locations, or participating online retail vision providers	$150	20%
Enhanced frame allowance at Visionworks locations nationwide	$200	20%

Participating Provider (In-Network) Benefits	
Davis Vision Collection – Frame (instead of allowance):	**Copay** You pay
Fashion Level	$0
Designer Level	$0
Premier Level	$0

Participating Provider (In-Network) Benefits	
Eyeglass Benefit – Eyeglass Lenses	**Copay** You pay
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	$10

Participating Provider (In-Network) Benefits	
Eyeglass Benefit – Lens Enhancements	**Copay** You pay
Tinting of Plastic Lenses	$0
Ultraviolet Coating	$12
Blue Light Filtering	$15
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch-Resistant Coating	$0
Anti-Reflective (AR) Coating ● Standard ● Premium ● Ultra ● Ultimate	 $35 $48 $60 $85
Progressive Lenses ● Standard ● Premium ● Ultra ● Ultimate	 $50 $90 $140 $175
Polycarbonate Lenses ● Children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater ● Adults	 $0 $30
High-Index Lenses ● 1.67 ● 1.74	 $55 $120
Scratch Protection Plan ● Single Vision ● Multifocal Lenses	 $20 $40

Participating Provider (In-Network) Benefits			
Contact Lens Benefit (instead of eyeglasses)	**Copay** You pay	**Allowance** The Plan pays up to	**Discount** on remaining costs
Evaluation, Fitting & Follow-Up Care – Standard Lens Types	$10	N/A	N/A
Evaluation, Fitting & Follow-Up Care – Specialty Lens Types ● Discount does not apply at Walmart, Sam's Club, Costco locations, or participating online retail vision providers	$10	$60	15%
Contact Lens: Materials Allowance ● Discount does not apply at Walmart, Sam's Club, Costco locations, or participating online retail vision providers	N/A	$150	15%

Participating Provider (In-Network) Benefits	
Visually Required Contact Lenses or Eyeglasses (preauthorization required)	**Copay** You pay
Evaluation, Fitting & Follow-Up Care, and Contact Lenses	$0
Eyeglasses	Standard copay and allowances apply

Participating Provider (In-Network) Benefits		
Davis Vision Collection – Contact Lenses (instead of allowance)	**Copay** You pay	**# of Boxes** The Plan pays up to
Evaluation, Fitting & Follow-up Care	$10	N/A
Disposable Contact Lens (Daily)	N/A	8
Contact Lens Planned Replacement	N/A	4

Participating Provider (In-Network) Benefits	
Low Vision Coverage (in-network and out-of-network combined coverage, preauthorization required)	**Allowance** The Plan pays up to
Low Vision comprehensive evaluation (One every 5 years up to allowance)	$300
Low Vision follow-up care (Four visits in a 5-year period up to allowance per visit)	$100
Low Vision Aid (up to allowance)	$600
● with lifetime allowance	$1,200

Nonparticipating Provider (Out-of-Network) Benefits	
Benefit	**Reimbursement Schedule** The Plan pays up to
Frame	$50
Single Vision Lenses	$40
Bifocal/Progressive Lenses	$60
Trifocal Lenses	$80
Lenticular Lenses	$100
Elective Contact Lenses	$105
Visually Required Contact Lenses or Eyeglasses (preauthorization required)	$225

Davis Vision Collection

Instead of the frame allowance, you and/or your dependent(s) may choose to select any frame from the Davis Vision Collection. The Collection is available at most participating independent provider offices and features three levels of frames.

Instead of the non-Collection contact lens allowance, you and/or your dependent(s) may be fitted with contact lenses from the Davis Vision Collection. Contact lenses from the Davis Vision Collection include the evaluation, fitting, and follow-up care.

Davis Vision is an independent company providing vision benefit management services and access to the Davis network. Each vision provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

Services that are not Covered

No benefits will be provided for services, materials, or charges detailed under “Schedule of Exclusions” unless defined within the “Schedule of Benefits” section of the benefit booklet.

Referrals are not required. Your vision care provider may suggest that you receive treatment from a specific provider or receive a specific treatment.

Even though your provider may recommend or provide written authorization for a referral for certain services, the vision care provider may be a nonparticipating provider or the recommended services may be excluded or limited.

When these services are referred or recommended, a written authorization from your provider does not override any provisions in the “Schedule of Benefits” or the “Schedule of Exclusions.”

No payment of benefits will be allowed under this plan for services you have already received prior to the effective date specified in the lower right-hand corner of the front cover.

Schedule of Exclusions

Except as specifically provided in this booklet, no program payment will be made for services or charges for examinations, materials, or products that are not listed as a covered service in the “Schedule of Benefits” section. Additionally, no plan payment will be made for the following:

Services and Procedures

1. Medical or surgical treatment of eye disease or injury.
2. Visual therapy.

3. Procedures determined by Blue Cross to be special or unusual, such as but not limited to:

    a. Orthoptics
    b. Vision training
    c. Tonography

4. Services or materials provided in connection with special procedures such as:

    a. Orthoptics and visual training (including but not limited to “Corneal Refractive Therapy (CTR, or “orthokeratology”).
    b. Medical or surgical treatment (including laser vision correction).

5. Laser vision correction.

6. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or services is:

    a. Paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan.
    b. Paid in any manner under any state law governing liability of injuries arising from the maintenance or use of a motor vehicle.

7. Services or supplies furnished to you or your covered dependent before the effective date of insurance under this benefit booklet or after the date you or your covered dependent’s insurance ends.

8. Services rendered by practitioners who do not meet the definition of vision care provider.

9. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from us or our authorized representative.

10. Refractions billed as a standalone service. Refractions are only offered as part of a full comprehensive eye examination.

Materials

1. Materials that do not provide vision correction such as EnChroma (color-blind glasses).
2. Temporary devices, appliances, and services.
3. Non-prescription industrial safety glasses and safety googles.
4. Sports glasses.
5. Incurred after the date of termination of your coverage except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date.
6. Duplicate devices, appliances and services.
7. Any lenses that do not require a prescription.
8. Prosthetic devices and services.
9. Visually required contact lenses or eyeglasses prescribed for you or your covered dependent for which prior approval was not obtained from us or our authorized representative.
10. Non-prescription (Plano) lenses.
11. Charges for the replacement of lost or stolen eyeglass lenses or frames or lost, stolen or damaged contact lenses and safety eyeglasses within the applicable benefit frequency period in the “Schedule of Benefits.”
12. Replacement of broken frames and eyeglass lenses.
13. Replacement of lost, damaged, or broken safety eyeglasses supplied by Davis Vision’s ophthalmic laboratories or any other manufacturer.

Benefits and other Expenses and Fees

1. Expenses or fees that you would have no legal obligation to pay in the absence of this or any similar coverage.

2. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

3. Treatment, services, or supplies that are provided at no charge.

4. To the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare benefits.

    a. This exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you so elect this coverage as primary.

5. Expenses covered by any other group insurance.
6. Expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer.
7. The cost of any insurance premiums indemnifying you against losses for lenses or frames.
8. Sales tax and shipping charges that may be associated with purchases of post-refractive products.

Miscellaneous Exclusions

1. Any condition caused by or resulting from declared or undeclared war or act thereof, while you or your dependents are in active service in the National Guard or in the Armed Forces of any country or international authority.
2. Services, materials, expenses, and/or fees incurred as a result of an injury sustained while committing a crime.

Choice of Provider

You may choose any licensed vision care provider for services.

However, choosing a participating provider may limit out-of-pocket expenses. Participating providers limit their fees to their contracted maximum allowable charges for covered services.

Also, if agreed by the provider, participating providers limit their charges for all services delivered to you and/or your dependent(s), even if the service is not covered for any reason and a benefit is not paid under this benefit booklet.

Participating providers also complete and send claims for covered services directly to us for processing.

To find a participating provider, visit our website at www.bluecrossmn.com or call the toll-free number on your member ID card.

When using a nonparticipating provider, you may have to pay the provider at the time of service, complete and submit your own claims, and/or wait for us to reimburse you. You will be responsible for the provider's full charge, which may exceed our maximum allowable charge and result in higher out-of-pocket expenses.

Payment of Benefits

This is a general summary of our vision care provider payment methodologies only. Although efforts are made to keep this information as up to date as possible, 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 benefit booklet.

We are not liable to pay benefits for any services started prior to a covered person's effective date of coverage. Procedures started prior to your and/or your dependent(s)'s effective date are the liability of you and/or your dependent(s).

This benefit booklet does not coordinate benefits with other vision care plans.

Participating Provider

When treatments are performed by a participating provider, we will pay covered benefits directly to the participating provider. Both you and the provider will be notified of benefits covered, our payment, and any out-of-pocket expenses.

Payment will be based on the maximum allowable charge the treating participating provider has contracted to accept. Maximum allowable charges may vary depending on the geographical area of the participating provider office and the contract between us and the particular participating provider rendering the service.

Participating providers agree by contract to accept maximum allowable charges as payment in full for covered services rendered to you and/or your dependent(s).

Nonparticipating Provider

When treatments are performed by a nonparticipating provider, benefits are substantially reduced, and you will likely incur significantly higher out-of-pocket expenses.

We will either send payment for covered services to you or we may choose to pay the nonparticipating provider. You will still be notified of the services covered, our payment, and any out-of-pocket expenses.

When we pay the nonparticipating provider, we have met our obligation under the benefit booklet. You may not assign your right, if any, to commence legal proceedings against Blue Cross.

Our payment will be based upon the maximum allowable charge for a covered service. You will be responsible to pay the nonparticipating provider any difference between our payment and the nonparticipating provider's full charge for the services. Nonparticipating providers are not obligated to limit their fees to our maximum allowable charges.

Who is Eligible for Coverage

If you, your spouse, and/or dependent(s) are group members of the group contractholder, you may be covered as either an employee or as a dependent, but not as both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Eligible Dependents

Your Spouse

Your spouse is:

1. The person to whom you are legally married.
2. Your partner through a civil union in a jurisdiction that recognizes civil unions.

Your Dependent Children

Dependent Children up to the limiting age:

1. Your children.
2. Your stepchildren.
3. Children of a legal civil union.
4. Children legally placed for adoption.
5. Children for whom you or your spouse have been appointed legal guardian.
6. Foster children.
7. Grandchildren who live with you or your spouse continuously from birth and are financially dependent upon you or your spouse.
8. Children awarded coverage because of a court order.

A dependent child's coverage automatically terminates, and all benefits hereunder cease at the end of the month the dependent reaches the limiting age or ceases to be a dependent as indicated above, whether or not notice to terminate is received by Blue Cross. See section "Disabled Dependent Children" in the "Enrollment and Effective Dates" section.

A dependent also includes a disabled dependent who is not able to support themselves because of developmental disability, mental illness or disorder, or physically disabled and primarily dependent upon the group member for support and maintenance.

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. You must check with your group contractholder to determine if you are responsible for all or a portion of these premiums.

Enrollment Periods

If you and any eligible dependents are enrolling after the original effective date of the group contract, the coverage will take effect as follows:

New Group Member Enrollment

You become eligible once you have satisfied the eligibility and probationary requirements as determined by the group contractholder.

Annual Open Enrollment Period

Annual enrollment effective date as agreed upon by the group contractholder and us.

Adding a Newborn or Adopted Child

If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days after the child's 3rd birthday.

If the child is not added within 30 days after the child's 3rd birthday, the child may be added only if there is a Special Enrollment Period or at the next open Enrollment Period, if any.

Disabled Dependent Children

Disabled dependent children who reach the limiting age may apply to continue coverage under this plan.

To be eligible for coverage, the child must meet the disabled dependent criteria in the "Eligible Dependents" 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 received within 31 days from when the child reaches the limiting age.

Special Enrollment Period

If you or any eligible dependents enroll after the initial enrollment or enrollment period, the date of coverage is determined based on the special enrollment process.

Special enrollment periods are when you or your eligible dependent(s) may enroll in the vision plan under certain circumstances after becoming eligible for coverage when all enrollment conditions are met. Unless otherwise specified, coverage will be made effective in accordance with applicable regulatory requirements.

Eligible Circumstances	The Group Member or Dependent	Request for coverage is received no later than	Effective date of coverage is
New dependent	can request coverage for the dependent because of: a. marriage, b. birth, c. adoption or placement for adoption or foster care, or d. court order	30 days after the event Refer to section "Adding a Newborn or Adopted Child"	the date of: a. marriage, b. birth, c. adoption or placement for adoption or foster care, or d. court order

Eligible Circumstances	The Group Member or Dependent	Request for coverage is received no later than	Effective date of coverage is
Loss of other group vision plan coverage	a. waived this vision coverage because they were covered under another group vision plan and b. is no longer covered under the other vision plan because: i. COBRA continuation has been exhausted (not due to failure to pay premium or for cause), ii. termination of employment, reduction in hours iii. death of the Employee, iv. he/she is no longer eligible for the plan due to a divorce or legal separation, v. loss of dependent status, vi. all employer contributions towards the coverage were terminated, or vii. the individual no longer lives or works in the service area	30 days after the termination of coverage or employer contribution	the day after the termination of prior coverage
Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage	a. waived this vision coverage because they were covered under Medicaid or CHIP and b. they must have been covered under Medicaid or CHIP at the time coverage was previously offered to the group member or dependent	60 days after the termination of Medicaid or CHIP coverage	a. 1st of the following month if your application is received between the 1st and the 15th of the month b. Otherwise, the effective date will be the 1st of the following second month
Eligibility for Premium Assistance through Medicaid or CHIP	must have documentation that they are eligible for premium assistance through Medicaid or CHIP from their employer	60 days after becoming eligible for premium assistance through Medicaid or CHIP	a. 1st of the following month if your application is received between the 1st and the 15th of the month b. Otherwise, the effective date will be the 1st of the following second month

Termination of This Plan

During the course of your coverage or a continuation period, if your marital status changes or a dependent ceases to be a dependent eligible for coverage under the terms of the group contract, you or your dependent must notify the plan administrator in writing. In addition, you must notify the plan administrator if a disabled group member or family member is no longer disabled.

You must provide notification to your group contractholder within 60 days of changes in you or your dependent's eligibility to obtain your continuation of coverage options. Refer to the "Continuation of Coverage" section for information regarding extension of coverage, or how to obtain an individual qualified plan.

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 dependents do not provide this required notice, you or your dependent must reimburse any claims mistakenly paid for expenses incurred after the date coverage actually terminates.

Termination Reasons and Termination Dates:

Event	What does this mean?	Who this applies to	Coverage Ends on the last day of the month that
Terminated for all group members	a. You will receive a 30-day notice of termination prior to the effective date of cancellation b. The notice will be sent using a list of addresses that is updated every 12 months c. You will not receive a notice if we have reasonable evidence that this coverage will be replaced by a similar policy, plan, or contract	Group member and dependents	As stated in the notice
Required premiums are not paid	a. Your employer must provide full payment of all premiums to us b. You must pay all premiums for continuation coverage	Group member and dependents	Premiums are due
Group member is no longer eligible	Your employer determines eligibility	Group member and dependents	Eligibility ends
Entering military service	Applies to duty lasting more than 31 days	Group member and dependents	Military service begins
Dependent is no longer eligible	Eligibility as defined in “Eligible Dependents” section	Dependents for which event applies	The event occurred
Group member terminates coverage	You request that coverage be terminated	Group member and dependents	The termination request is received
Determination of fraud or misrepresentation	We determine that you have committed fraud or misrepresentation regarding eligibility or any other material fact	Group member and dependents	Date we determine fraud or misrepresentation committed

Benefits After Coverage Terminates

We are not liable to pay any benefits for covered services that are started after you or your dependent(s) have been terminated.

However, coverage for completion of a vision procedure requiring two or more visits on separate days will be extended for a period of 90 days after the termination date to allow for the procedure to be finished. The procedure must be started prior to the termination date.

Fraudulent Practices

Coverage for you and/or your dependent(s) will be terminated if you and/or your dependent(s) engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to:

1. Submitting fraudulent misstatements or omissions about your vision history or eligibility status on the enrollment form for coverage,
2. Submitting fraudulent, altered, or duplicate billings for personal gain, or
3. Allowing another party not eligible for coverage under the benefit booklet to use your and/or your dependent's coverage.

Continuation of Coverage

Type of Coverage

Generally, continuation coverage is the same coverage that you or your dependent had on the day before the qualifying event. You have the same rights under this plan as active employees or their dependents as noted under “Annual Open Enrollment” and “Special Enrollment.”

Qualifying Events

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

NOTE: You may have a right to Special Enrollment in a new plan such as an individual vision plan or another employer plan.

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is earlier or earliest of
Termination of employment	Voluntary or involuntary termination for reasons other than gross misconduct	Group member and dependents	a. 18 months from the 1st of month following the event, or b. Enrollment date in other group coverage
Reduction in the hours	Due to lay-off, leave of absence, strike, lockout, change from full-time to part-time employment		
Total disability of group member	a. You are not able to engage in or perform the duties of your regular occupation or employment within the first two years of disability b. After the first two years, you are not able to perform any occupation for which you are educated or trained	Group member and dependents	a. Date total disability ends, or b. Date coverage would otherwise end
Death of the group member		Dependents	a. Enrollment date in other group coverage, or b. Date coverage would otherwise end if the group member had lived
Group member becomes enrolled in Medicare		Dependents	a. 36 months from date of event, or b. Enrollment date in other group coverage, or c. Date coverage would otherwise end

Qualifying Event	What does this mean?	Who May Continue	Maximum Continuation Period is earlier or earliest of
Divorce or legal separation	a. Spouse/ex-spouse was covered on the day before the entry of the valid decree of dissolution of marriage b. If coverage for Spouse was terminated in anticipation of the divorce or legal separation, a later divorce or legal separation is considered a qualifying event	Spouse/ex-spouse and any dependent children who lose coverage	a. Enrollment date in other group coverage, or b. Date coverage would otherwise end
Dependent Child is no longer eligible	Eligibility as defined in "Eligible Dependents" section	Dependent Child	a. 36 months from date of event, or b. Enrollment date in other group coverage, or c. Date coverage would otherwise end
Group contractholder filing Chapter 11 bankruptcy	a. You are a retiree of the group contractholder filing Chapter 11 bankruptcy b. includes substantial reduction in coverage within one year of filing	Retiree	Lifetime continuation.
		Dependents	Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death
		Surviving Spouse	a. Lifetime continuation until the retiree dies, then an additional 36 months following retiree's death b. Lifetime continuation when retiree is deceased at time of event and spouse is already covered by the group contract

Qualifying Event Extensions

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

Total Disability of Dependent(s)

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

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

Second Qualifying Event

1. You have continuation coverage because group member was terminated from employment or had a reduction of hours, and
2. the second qualifying event occurs prior to end of the 18-month continuation period or 29-month disability extension, and
3. the second qualifying event has at least a 36-month continuation period.

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

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

Group Member Enrolled in Medicare

1. Group member is enrolled in Medicare, and
2. later experiences termination of employment or a reduction in the hours worked, and
3. this occurs within 18 months after the date of the group member's Medicare enrollment.

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty, the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

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

Continuation Notice Obligations

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

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

If you or your dependent's address changes, you *must* notify the plan administrator in writing so the plan administrator may mail you or your dependent important continuation notices and other information.

You and your dependents may elect continuation coverage even if covered under another employer-sponsored group vision plan or enrolled in Medicare.

Contact the group contractholder to determine how to elect continuation coverage.

Notices for	Group Member /Dependent	Group Contractholder	Eligible Group Member / Dependent
Contract Termination due to a. Termination of employment b. Reduction in the hours c. Death of the group member d. Group member becomes enrolled in Medicare	Notice must be provided to group contractholder within 60 days of the event if group contractholder is not aware of the event	Send the qualifying event notice to eligible individuals within 14 days of the event or upon receipt of notice to advise a. of the right to elect continuation coverage or b. when continuation is not available and why	Elect continuation coverage within 60 days of a. the qualifying event or b. the date of the qualifying-event notice, whichever is later

Notices for	Group Member /Dependent	Group Contractholder	Eligible Group Member / Dependent
Contract Termination due to a. Divorce or legal separation b. Dependent Child is no longer eligible	a. Notice must be provided to group contractholder within 60 days of the event b. Notice must be provided to group contractholder within 60 days after a later divorce or legal separation when coverage was earlier terminated in anticipation of the divorce or legal separation	Upon receipt of notice, notify the eligible individuals a. of the right to elect continuation coverage or b. when continuation is not available and why	Elect continuation within 60 days a. of the qualifying event, or b. the date of the qualifying event notice, whichever is later
Extension of continuation due to a. Disability determination or b. New qualifying event	Notice must be provided a. to group contractholder within 60 days of the disability determination or new event and b. before the end of the initial 18-month or 29-month continuation period	Upon receipt of notice a. notify the eligible individuals of the right to elect continuation coverage, or b. notify you when an extension is not available and why	Elect continuation within 60 days a. of the qualifying event, or b. the date of the qualifying event notice, whichever is later

Termination of Continuation Coverage Before the End of Maximum Coverage Period

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

1. The group contractholder no longer provides group vision coverage to any of its employees.
2. The premium for continuation coverage is not paid when due.
3. If during an 18-month or 29-month maximum coverage period due to disability the SSA makes the final determination that the qualified beneficiary is no longer disabled. You must notify the group contractholder within 30 days of the final determination.
4. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to any covered group members or their dependents whether or not they are on continuation coverage.
5. Voluntarily canceling your continuation coverage.

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

Continuation Premiums

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

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

If the qualifying event for continuation is the group member's total disability, the administration fee is not permitted.

All premiums are paid directly to the group contractholder.

Reimbursement and Subrogation

If we pay benefits for expenses you incur as a result of any act of any person, and you later obtain full compensation, you are obligated to reimburse us for the benefits paid.

If you or your dependents receive benefits under this plan arising out of an 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 extent we provided any benefits.

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. For the purposes of this section, full recovery does not include payments made by a vision plan to, or for the benefit of, a covered person.

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

Notice Requirement

You must provide timely written notice to us of the pending or potential claim if you make a claim against a third party for damages that include repayment for expenses incurred for your benefit.

We may take appropriate action to preserve our rights under this Reimbursement and Subrogation section, including our right to intervene in any lawsuit you have commenced.

Duty to Cooperate

You must cooperate with Blue Cross in assisting it to protect its legal rights under this provision.

You agree that the limited period in which we may seek reimbursement or to subrogate does not commence to run until you or your attorney has given notice to us of your claim against a third party.

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 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 and vision providers to give us needed information about the care they provide to you.

We may need this information to process:

1. Claims
2. Conduct Utilization Review
3. Conduct care management and quality improvement activities
4. Reimbursement and subrogation review
5. Other vision 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.

Claims Process

Notice of Claim

Written notice of claim must be given to Blue Cross within 20 days after the occurrence or commencement of any loss covered by the benefit booklet, or as soon thereafter as is reasonably possible.

Notice given by or on behalf of you or your covered dependent(s) to Blue Cross, with information sufficient to identify the person making the claim, shall be deemed notice to Blue Cross.

Claim Forms

Upon receipt of a notice of claim, we will furnish to you such forms as are usually furnished by us for filing proof of loss.

If such forms are not furnished before the expiration of 15 days after we received notice of any claim under the benefit booklet, the person making such claim shall be deemed to have complied with the requirements of the benefit booklet as to proof of loss upon submitting within the time fixed in the benefit booklet for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to us at our office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time Payment of Claims

All benefits payable under this benefit booklet for any loss will be paid immediately after receipt of due written proof of such loss.

Payment of Claims

All benefits under this benefit booklet shall be payable to your participating provider, you, or your dependent. When the dependent is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the custodial parent, guardian, or other person actually providing support.

At the option of Blue Cross and unless you request otherwise in writing not later than the time of filing proofs of such loss, all or a portion of any indemnities provided by this benefit booklet on account of vision services may, be paid directly to the participating vision office rendering such services.

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

Right of Examination

We have the right to ask you to be examined by a vision care provider during the review of any claim. We choose the vision care provider and pay for the exam whenever we request this.

We also have the right to make an autopsy in case of death where it is not forbidden by law.

Review of a Benefit Determination

If you are not satisfied with a benefit determination or payment, please contact our customer service department at the toll-free telephone number listed in the “Questions?” section or on the back of your member ID. We will try to resolve your oral complaint as quickly as possible.

However, if after speaking with a customer service representative, our resolution of your oral complaint is wholly or partially adverse to you or not resolved to your satisfaction, within 10 days of our receipt of your oral complaint, you may submit an appeal in writing.

We will provide you a complaint form on which you can include all the necessary information to file your appeal. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

You must tell us all reasons and arguments in support of your appeal, and you must identify and provide all evidence in support of your appeal unless that evidence is already in our possession. Refer to the “Appeal Process” below. Contact us for further steps you can take regarding your claim.

Appeal Process

Appeals Procedure Definitions

The following definitions apply to the appeal procedures:

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

Appeal – Any grievance that is not the subject of litigation concerning any aspect of the provision of services under your group contract. If the appeal is from an applicant, the appeal must relate to the application. If the appeal is from a formerly covered person, the appeal must relate to the provision of vision services during the period of time the covered person was enrolled in the Plan.

Appeal Procedures

If we decide a claim that is wholly or partially adverse to you, and you wish to appeal, you are required to submit an appeal. You have 180 days from the date you received notice of the Adverse Benefit Determination to appeal the decision. You can call or write us with your appeal. You or anyone you authorize to act on your behalf may submit your appeal in writing, or you may request a complaint form. We will send a complaint form to you upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature.

The request for an appeal should include:

1. The covered person's name, identification number, and group number
2. The pre-service claim or post-service claim for which coverage was denied
3. A copy of the denial
4. The reason why you or your vision care professional believes the service should be covered
5. Any available medical information you believe will be helpful to the decision.
6. Your appeal must state all reasons and arguments in support of the appeal, and you must submit all evidence in support of your appeal, unless that evidence is already in our possession

Send your Appeal to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

In addition, you may file your appeal with the Minnesota Commissioner of Commerce at any time by calling (651) 539-1600 or toll-free 1-800-657-3602.

When a medically necessary determination is needed to resolve your appeal, we will process your appeal using utilization review appeal procedures. Utilization review applies a well-defined process to determine whether vision care services are medically necessary and eligible for coverage. The decision on this appeal will be made by a vision care professional who did not make the initial determination. Utilization review applies only when the service requested is otherwise covered under this vision plan. In order to conduct utilization review, we will need specific information. If you or your attending vision care professional do not release necessary information, approval of the requested service, procedure, or admission to a facility may be denied.

Expedited Appeal

When a prior authorization decision is wholly or partially adverse to you and your attending vision care professional believes that an expedited appeal is warranted, you and your attending vision care professional may request an expedited appeal. You and your attending vision care professional may appeal the determination over the telephone. Our appeal staff will include the consulting vision care provider if reasonably available. When an expedited appeal is completed, we will notify you and your attending vision care professional of the decision as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from our receipt of the expedited appeal request.

Standard Appeal

We will notify you that we have received your written appeal.

When a medically necessary determination is needed to resolve your appeal, we will inform you of our decision and the reasons for the decision within 15 days of receiving your appeal and all necessary information. If we are unable to make a decision within 15 days due to circumstances outside our control, we may take up to 4 additional days to make a decision. If we take more than 15 days to make a decision, we will inform you of the reasons for the extension.

For all other appeals, we will inform you of our decision and the reasons for the decision within 30 days of receiving your appeal and all necessary information. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension.

If we need specific information, including medical records, to complete our review and you or your vision care professional does not release the requested information. Your claim may be denied. You have the right to review the information that we relied on in the course of the appeal.

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

General Information

Entire Contract

This benefit booklet, including the endorsements, and the attached papers if any, the employer application, the employee enrollment form, and the group contract issued to the group contractholder make up the entire contract of coverage. The master group contract is available for your inspection at your group contractholder's office. Your group contractholder is the Plan Administrator for your coverage plan.

All statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the contract, unless it is contained in the written enrollment form.

This benefit booklet is issued and delivered in the state of Minnesota. It is subject to the substantive laws of the state of Minnesota, without regard to its choice of law principles; and, it is not subject to the substantive laws of any other state.

Changes to the Contract

The group contractholder reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the vision care plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the vision plan.

The group contractholder may add/change eligible classes of employees from time to time, and such changes will be noted in the group contract.

Any amendment to this vision plan may be effected by a written resolution adopted by the Plan Administrator. Blue Cross will communicate any adopted changes to the group contractholder not later than 60 days before the date on which the adopted changes will become effective.

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

Time Limit for Misstatements

If there is any misstatement in the written enrollment form that the group contractholder completes, we cannot use the misstatement to cancel coverage that has been in effect for, or deny a claim incurred on a date that is on or after, two years or more from the initial date of coverage issued as a result of that enrollment form. This time limit does not apply to fraudulent misstatements.

Indemnity for Loss of Life

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 which may be prescribed herein and 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.

Change of Beneficiary

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.

Assignment

Blue Cross may assign this contract and its rights and obligations hereunder.

Conformity with State Laws

Any part of the contract in conflict with the laws of the state where the group member lives on the contract’s effective date is changed to conform to the minimum requirements of that state’s law.

Legal Actions

No action at law or in equity shall be brought to recover on the benefit booklet prior to the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the benefit booklet.

No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

No Third-Party Beneficiaries

The benefits described in this plan are intended solely for the benefit of you and your covered dependents.

No one else may claim to be an intended or third-party beneficiary of this plan.

No one other than you or your dependents may bring a lawsuit, claim or any other cause of action related in any way to this plan, and you may not assign such rights to any other person.

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

As required by law, Blue Cross 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; and
3. Native nations, tribal organizations, and Urban Indian Organizations.
4. 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 Cross 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 Cross is not required by law to accept third-party premium and/or cost-sharing payments.

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

1. Cash
2. Check
3. Money order
4. Credit card payment
5. Electronic fund transfer, etc.

Third parties not listed above (or from whom Blue Cross 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 maximum. "Cost-sharing” includes payments such as deductibles, copays and coinsurance. Blue Cross may make retroactive adjustments to account for any payments made by ineligible third parties.

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

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

Blue Cross maintains sole discretion with respect to its acceptance of third-party payments. Blue Cross 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 Cross will accept premium and/or cost-sharing payments made by a specific person or entity, please contact Customer Service at the number located on the back of your member ID Card.

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

Premium Payment

We charge your employer a monthly rate (premium). We may revise this rate during the plan year due to changes in the group's status.

Your monthly contribution amount (if any) is determined by your employer.

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.

Terms You Should Know

Allowance – A maximum dollar amount allowed as a benefit for a covered service from a participating vision care provider. The allowance levels are shown in the "Schedule of Benefits." If the provider's charge is less than the allowance we will only pay up to the provider's charge. You are responsible for any amount over the allowance.

Benefit Booklet – This document, including schedules, addenda and/or endorsements, if any, which are attached to the benefit booklet and describe the vision coverage purchased from Blue Cross.

Blue Cross – BCBSM, Inc. dba Blue Cross and Blue Shield of Minnesota shown on the front page of this benefit booklet, its affiliate or a third party with which Blue Cross contracts for a provider network and/or to perform certain functions to administer the terms of this benefit booklet. Also referred to as "we," "our," or "us."

Blue Light Filtering – Coating added to the lenses, or included in a lens that blocks or absorb blue light.

Coinsurance – Those remaining percentages or dollar amounts of the maximum allowable charge for a covered service that are the responsibility of you and/or your dependent(s) after Blue Cross pays the percentages or dollar amounts shown on the "Schedule of Benefits for a covered service."

Contact Lens Planned Replacement – Contact lenses worn for a prescribed period of time and replaced at regular intervals.

Copay – The dollar amount you must pay for certain covered services. The "Schedule of Benefits" lists the copay and services that require copay.

Covered Service(s) – Services shown on the "Schedule of Benefits" for which benefits will be covered subject to the "Schedule of Exclusions."

Discount – The percentage that a participating vision care provider has agreed to reduce your and/or your dependent(s)'s charge for the requested service, material or procedure. Discounts are shown in the "Schedule of Benefits." Discounted vision services, materials, supplies and treatments described in the "Schedule of Benefits" are not underwritten by us.

Disposable Contact Lens – Contact lenses meant to be worn once and thrown away daily.

Effective Date – The date on which the benefit booklet begins or the date on which coverage for a covered person begins.

Enrollment Period – A period of time agreed upon by the group member and us or our authorized representative during which a member may apply for insurance.

Eye Examination – An exam or eye examination means services including but not limited to: Case history-chief complaint, eye and vision history, medical history; Entrance distance acuities; External ocular evaluation including slit lamp examination; Internal ocular examination; Tonometry; Distance refraction-objective and subjective; Binocular coordination and ocular motility evaluation; Evaluation of pupillary function; Biomicroscopy; Gross visual fields; Assessment and plan; Advising on matters pertaining to vision care; Form completion-school, motor vehicle, etc.; Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when professionally indicated.

Exclusion(s) – Services, supplies, or charges that are not covered under the benefit booklet as stated in the "Schedule of Exclusions."

Frequency – The time period shown in the "Schedule of Benefits" during which you are eligible for the covered services shown in the "Schedule of Benefits." This time period is measured from the date of your last eye examination or the date you received the eyeglasses, frame or eyeglass lenses or contact lenses.

Group Member(s) – The employee for whom coverage has been provided by the contractholder.

Limitation(s) – The maximum frequency or age limit applied to a covered service set forth in the "Schedule of Exclusions."

Limiting Age – The age for a dependent child defined as when a dependent child reaches age 26 or the age when a dependent child is found to no longer be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the group member for maintenance and support.

Low Vision – A condition caused by eye disease, in which visual acuity is 20/70 or poorer in the better-seeing eye and cannot be corrected or improved with regular eyeglasses.

Materials – Frames and lenses provided to a covered person for ophthalmic correction under the terms and conditions of the benefit booklet.

Maximum(s) – The greatest amount Blue Cross is obligated to pay for all covered services rendered during a specified period as shown on the "Schedule of Benefits."

Maximum Allowable Charge(s) – The greatest amount the benefit booklet will allow for a specific service.

Nonparticipating Provider(s) – A vision care provider who has not contracted with us to limit his/her charges to you and/or your dependent(s).

Ophthalmologist – A physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform eye examination and refractive services.

Optician – A technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses upon prescription to the intended wearer.

Optometrist – A professional provider, licensed where required, who examines, diagnoses, treats and manages diseases, injuries and disorders of the visual system, the eye and associated structures as well as identifies related systemic conditions affecting the eye.

Orthoptics – The diagnosis and non-surgical treatment of irregularities of the eyes, especially those of the eye muscles that prevent normal binocular vision.

Out-of-Pocket Expense(s) – Costs not paid by us, including but not limited to coinsurance, deductibles, amounts billed by nonparticipating vision care providers that are over the maximum allowable charge, costs of services that exceed the benefit booklet limitations or maximums, or for services that are exclusions. The covered person is responsible to pay for out-of-pocket expenses.

Participating Provider(s) – A vision care provider who has executed a participating vision care provider agreement with us, under which he/she agrees to accept maximum allowable charges as payment in full for covered services. Participating providers may also agree to limit their charges for any other services delivered to you and/or your dependent(s).

Plan Year – The period of 12 months beginning on the effective date or the anniversary of the effective date of the group member's benefit booklet and ending on the day before the renewal date.

Polarized Lenses – Eyeglass lenses that are either green, gray or brown and that redirect the way light enters the lens.

Polycarbonate Lenses – Impact resistant and lightweight eyeglass lenses.

Premium Anti-Reflective Coating (ARC) – A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Crizal™, Carl Zeiss Carat Gold™, etc.)

Premium Progressive Lenses – All-distance lenses that have no line but progress from distance to intermediate, to near (i.e. Varilux™, etc.)

Premium(s) – Payment that must be remitted in exchange for coverage of you and/or your dependent(s) under the benefit booklet.

Renewal Date – The date the benefit booklet renews.

Reimbursement – A flat dollar amount payable under this benefit booklet towards a covered service from and nonparticipating provider. Reimbursement levels are shown in the "Schedule of Benefits." If the provider's charge is less than the reimbursement, we will only pay up to the provider's charge. You are responsible for any amount over the reimbursement payment.

Schedule of Benefits – The summary of covered services, benefit booklet payments, deductibles, and maximums applicable to benefits payable under the benefit booklet.

Schedule of Exclusions – The list of exclusions applicable to benefits, services, supplies, or charges under the benefit booklet.

Scratch-Resistant Coating – Coating applied to eyeglass lenses to increase the scratch resistance of the lens surface.

Standard Anti-Reflective Coating (ARC) – A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Reflection Free™, Carl Zeiss Gold ET™, etc.)

Standard Progressive Lenses – All-distance eyeglass lenses that have no line but progress from distance to intermediate, to near (i.e. AO Compact™, Sola VIP™, etc.)

Termination Date – The date on which the vision coverage ends for a covered person or on which the benefit booklet terminates.

Tinted Plastic Lenses –

1. Fashion tinting – Eyeglass lenses dyed or coated with pigment of uniform color and density throughout the entire lens.
2. Gradient tinting – Eyeglass lens coating that is darker at the top of the lens, fading to light at the bottom of the lens.

Tonography – The procedure of recording measurements (as of intraocular pressure) with a tonometer3.

Ultra Anti-Reflective Coating (ARC) – A clear coating placed on eyeglass lenses that limits light reflection by allowing the maximum amount of light to pass through the lens (i.e. Essilor Alize™ with Clear Guard, Carl Zeiss Carat Advantage Gold™, etc.)

Ultraviolet Coating – A coating on plastic or glass eyeglass lenses that blocks ultraviolet rays.

Vision Care Provider(s) – A person licensed in the state in which vision services are provided. A vision care provider will include other duly licensed Ophthalmologist, Optician and Optometrist under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Vision Training – The visual training, also called visual or vision therapy is a part of optometry who is responsible for developing, improving and intensifying the visual skills that can be acquired. The visual training provides the opportunity to learn how to use the vision of a more efficient way.

Vision Therapy – A program that aims to improve a person's visual abilities. It uses a variety of ways – such as eye exercises, testing, occlusion (patching) lenses and prisms – to treat a range of visual problems. Vision therapy may be used to treat problems such as: amblyopia (lazy eye).

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. Toperform 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.

Toprevent 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. Youradditional rights are described below:

Yourrighttorequestrestrictions. Youhavethe 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 yougivemyprotected 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: Whoshould I contact toget 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 myprivacyrights 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.

F7676R15 (04/23)