



**BlueCross
BlueShield**

Minnesota

2016 CERTIFICATE OF COVERAGE

Coordinated Plan

State of Minnesota Retirees

ANNUAL NOTIFICATIONS

General Provider Payment Methods

Participating Providers

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

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

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

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

- **Institutional (i.e., hospital and other facility) Participating Provider Payments**

- **Inpatient Care**

- **Payments for each Case (case rate)** – Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier"). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
- **Payments for each Day (per diem)** – Providers are paid a fixed amount for each day the patient spends in the hospital or facility.
- **Percentage of Billed Charges** – Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.

- **Outpatient Care**

- **Payments for each category of services** – Providers are paid a fixed or bundled amount for each category of outpatient services a member received during one (1) or more related visits.
- **Payments for each visit** – Providers are paid a fixed amount for all related services a member receives in an outpatient or home setting during one (1) visit.
- **Payments for each patient** – providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

Special Incentive Payments

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

Nonparticipating Providers

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

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

- **Example**

The following table illustrates the different out-of-pocket costs you may incur using Nonparticipating versus Participating Providers. The example presumes that your deductible has been satisfied and that the Plan covers 80% for Participating Providers and 60% for Nonparticipating Providers. It also presumes that the Allowed Amount for a Nonparticipating Provider will be less than for a Participating Provider. The difference in the Allowed Amount between a Participating and Nonparticipating Provider could be more or less than the 20% difference in the example below.

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

Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the Provider of care, such as hospital-based Providers (e.g., anesthesiologists) who may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the Allowed Amount and the Provider's billed charges. However, in circumstances where you needed care, and were not able to choose the Provider who rendered such care, Blue Cross may pay an additional amount. The extent of reimbursement in certain Medical Emergency circumstances may also be subject to state and federal law – please refer to “Emergency Care” for coverage of benefits.

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

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

Women's Health and Cancer Rights Act

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

1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
3. prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

Blue Cross and Blue Shield of Minnesota Member Rights and Responsibilities

YOU HAVE THE RIGHT AS A HEALTH PLAN MEMBER TO:

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

YOU HAVE THE RESPONSIBILITY AS A HEALTH PLAN MEMBER TO:

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

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INTRODUCTION

State Retiree Coordinated Plan

This certificate is issued and delivered in the state of Minnesota, is subject to the laws of the state of Minnesota, and is not subject to the laws of any other state.

This certificate describes the State Retiree Coordinated Plan (SRCP). For purposes of this certificate, “you” or “your” refers to the group member named on the identification (ID) card. Group member is the person for whom the group contractholder has provided coverage. The group contractholder has contracted with us to provide coverage for its group members. “We,” “us,” and “our” refer to Blue Cross and Blue Shield of Minnesota (Blue Cross). Other terms are defined in the “Definitions” section.

This certificate describes your health care coverage. It replaces all other certificates you have received from us. This certificate explains the Plan, eligibility, notification procedures, covered expenses, and expenses that are not covered. It is important that you read this entire certificate carefully. If you have questions about your coverage, please contact us at the address or telephone numbers listed on the “Customer Service” page.

Coverage under this Plan for eligible group members will begin as defined in the “Eligibility” section.

This Plan is a fully insured medical plan. Blue Cross is the insurer and the claims administrator. Coverage is subject to all terms and conditions of this certificate, including medical necessity.

The Plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use Participating Providers. Participating Providers are providers that have entered into a network contract with us to provide you quality health services at favorable prices.

The Plan also provides benefits for covered services you receive from Nonparticipating Providers. In some cases, you receive a reduced level of coverage when you use these providers. Nonparticipating Providers have not entered into a network contract with us. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

IMPORTANT! When receiving care, present your ID card to the provider who is rendering the services.

CUSTOMER SERVICE

<p>Questions?</p>	<p>The Blue Cross customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification. Our customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.</p> <p>Monday-Friday: 7:00 a.m. - 8:00 p.m. United States Central Time</p> <p><i>Hours are subject to change without prior notice.</i></p>
<p>Customer Service Telephone Number</p>	<p>(651) 662-5090 or toll-free 1-800-262-0819 TDD: (651) 662-8700 or toll-free 1-888-378-0137</p>
<p>Blue Cross and Blue Shield of Minnesota Website</p>	<p>www.bluecrossmn.com</p>
<p>BlueCard Telephone Number</p>	<p>Toll-free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.</p>
<p>BlueCard Website</p>	<p>www.bcbs.com This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.</p>
<p>Mailing Address</p>	<p>Claims review requests, and written inquiries may be mailed to the address below:</p> <p style="padding-left: 40px;">Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164</p> <p>Prior authorization requests should be mailed to the following address:</p> <p style="padding-left: 40px;">Blue Cross and Blue Shield of Minnesota Utilization Management Department P.O. Box 64265 St. Paul, MN 55164</p>
<p>Office Address</p>	<p>You may visit our Home Office during normal business hours:</p> <p style="padding-left: 40px;">Blue Cross and Blue Shield of Minnesota RiverPark II 1800 Yankee Doodle Rd. Eagan, MN 55122</p>

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

DISTRICT OFFICES

MINNEAPOLIS/ST. PAUL

RiverPark II
1800 Yankee Doodle Rd.
Eagan, MN 55122

1-800-262-0819 (NATL)
1-651-662-5090
1-651-662-0038 (FAX)
1-651-662-8700 (TDD/TTY)

DULUTH

405 West Superior St.
Duluth, MN 55802

1-800-232-1383 (NATL)
1-218-722-3371
1-218-722-3830 (FAX)

COVERAGE INFORMATION

Choosing a Health Care Provider

You may choose any eligible provider of health services for the care you need. We may pay higher benefits if you choose Participating Providers.

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

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

Participating Providers

When you choose these providers, you get the most benefits for the least expense and paperwork. These providers send your claims to us and we send payment to the provider for covered services you receive. The provider directory lists Participating Providers and may change as providers initiate or terminate their network contracts. For benefit information, refer to the "Benefit Chart."

The SRCP covers eligible services when Participating Providers are used. If you choose to use a Nonparticipating Provider, the SRCP still covers eligible services but at a lower payment level. For the highest level of coverage, use Participating Providers. If you reside outside the state of Minnesota or travel world-wide, you need to be aware of your responsibilities when you use a Nonparticipating Provider.

Nonparticipating Providers

Nonparticipating Providers may not take care of notification requirements or file claims for you. You may also pay more of the bill. Refer to the "Liability for Health Care Expenses" section for a description of charges that are your responsibility.

Liability for Health Care Expenses

Charges That Are Your Responsibility

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

1. deductibles and coinsurance;
2. charges that exceed the benefit maximum;
3. charges for services that are not covered; and,
4. charges for services that are investigative or not medically necessary if you are notified in writing before you receive services that the services are not covered and you agree in writing to pay all charges.

When you use Nonparticipating Providers for covered services, payment is still based on the allowed amount. However, because a Nonparticipating Provider has not entered into a

network contract with us, the Nonparticipating Provider is not obligated to accept the allowed amount as payment in full.

You are responsible for payment of any billed charges that exceed the allowed amount. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

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

Recommendations by Health Care Providers

In some cases, your provider may recommend or provide written authorization for services that are specifically excluded by the Plan. When these services are referred or recommended, a written authorization from your provider does not override any specific Plan exclusions.

Fraudulent Practices

Coverage for you will be terminated if you engage in fraud of any type including, but not limited to: submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the Plan to use your coverage.

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.

Medical Policy Committee and Medical Policies

Our Medical Policy Committee develops medical policies that determine whether new and existing treatments should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered. Our medical policies can be found at www.bluecrossmn.com and are hereby incorporated by reference.

Accommodation Provision

It is the policy of Blue Cross to treat all persons alike, without distinctions based on race, color, religion, national origin, handicap, sex or age. If you have questions about this policy, contact Customer Service at (651) 662-5090 or toll-free 1-800-262-0819. Hearing impaired members with a TDD telephone may contact Customer Services at (651) 662-8700 or toll-free 1-888-878-0137. If you have an impairment that requires alternative communication formats such as Braille, large print or audio cassettes, please request these materials from Customer Service at the telephone numbers listed above. If this Certificate is provided in one of these alternative communication formats, this written version governs all coverage decisions.

NOTIFICATION REQUIREMENTS

Blue Cross reviews 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, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification.

Prior authorization, preadmission notification, preadmission certification, and emergency admission notification are required.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered.

For **inpatient hospital/facility** services, Participating Providers are required to obtain prior authorization for you. You are responsible for obtaining prior authorization when receiving **inpatient hospital/facility services** from Nonparticipating Providers.

For **outpatient hospital/facility services or professional services**, Minnesota participating providers are responsible for obtaining prior authorization for you. You are required to obtain prior authorization when you use Participating Providers outside Minnesota and Nonparticipating Providers. However, some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you.

Minnesota Participating Providers who do not obtain prior authorization for you are responsible for the charges if the services are found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges. We require that you or the provider contact us at least 10 working days prior to receiving the care to determine if the services are eligible. We will notify you of our decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

Blue Cross reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on our website at www.bluecrossmn.com (choose the "Providers" tab in the lower left corner, then the "Medical Policy" tab under "Tools and Resources") or call Customer Service.

We prefer that all requests for prior authorization be submitted to us in writing to ensure accuracy. Please refer to the "Customer Service" section for the telephone number and appropriate mailing address for prior authorization.

Preadmission Notification

Preadmission notification is a process whereby the provider, or you, inform us that you will be admitted for inpatient hospitalization services. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

All Participating Providers are required to provide preadmission notification for you.

We also recommend that you obtain prior authorization for the services related to the inpatient admission. Please refer to "Prior Authorization" in this section. If you are going to receive nonemergency care from a Nonparticipating Providers, you are required to provide preadmission notification to us. Some of these providers may provide preadmission notification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for services related to the inpatient admission. Please refer to "Prior Authorization" in this section. Minnesota Participating Providers who do not obtain preadmission notification for you are responsible for the charges, if the admission is found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

1. Hospital acute care admissions;
2. Residential behavioral health treatment facilities; and,
3. Mental health and substance abuse admissions.

To provide preadmission notification, call the Customer Service telephone number provided in the "Customer Service" section. They will direct your call.

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or services. Preadmission certification includes concurrent/length-of-stay review for inpatient admissions. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

All Participating Providers are required to provide preadmission certification for you.

If you are going to receive nonemergency care from Nonparticipating Providers, you are required to provide preadmission certification to us. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you. **You are also required to obtain prior authorization for the services related to the inpatient admission. Please refer to "Prior Authorization" in this section. Minnesota Participating Providers who do not obtain preadmission notification for you are responsible for the charges, if the admission is found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

1. Acute rehabilitation (ACR) admissions;
2. Long-term acute care (LTAC) admissions; and,
3. Skilled nursing facilities.

To provide preadmission certification, call the Customer Service telephone number in the "Customer Service" section. They will direct your call.

Emergency Admission Notification

In order to avoid liability for charges that are not considered medically necessary, you are required to provide emergency admission notification to us as soon as reasonably possible after an admission for pregnancy, medical emergency, or injury that occurred within 48 hours before admission.

Minnesota Participating Providers are required to provide emergency admission notification for you and are responsible for charges for any services found to be not medically necessary.

If you receive care from Out-of-Network Providers in Minnesota or any Provider outside Minnesota, you are required to provide emergency admission notification to us within 48 hours of the admission or as soon as reasonably possible after admission for pregnancy, medical emergency, or injury. Some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you. **If this notification is not provided and it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

To provide emergency admission notification, call the Customer Service telephone number provided in the "Customer Service" section. They will direct your call.

BENEFIT CHART

This section lists covered services and the benefits this we pay. All benefits are based upon the allowed amounts. Coverage is subject to all terms, conditions, and definitions of this certificate and must be medically necessary.

This coverage is not a qualified plan.

Benefit Features, Limitations, and Maximums

Benefit Features	Your Liability
Deductible <ul style="list-style-type: none">Coordinated Plan Deductible	\$200 per person per calendar year for inpatient hospital/facility charges
Benefit Features	Limitations and Maximums
Out-of-Pocket Maximum <ul style="list-style-type: none">Inpatient hospital/facility charges	You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
Lifetime Maximum <ul style="list-style-type: none">Total benefit paid to all providers combined	Unlimited

Benefit Descriptions

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

AMBULANCE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none">• Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition• Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	100%.
NOT COVERED: <ul style="list-style-type: none">• transportation services that are not medically necessary for basic or advanced life support• transportation services that are mainly for your convenience including costs related to transportation to a facility that is not the nearest medical facility equipped to treat the condition• please refer to the “General Exclusions” section	

CHEMICAL DEPENDENCY

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> Outpatient health care professional charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/outpatient behavioral health facility charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient health care professional charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient hospital/ residential behavioral health facility charges for semi-private room up to 365 days 	You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
<ul style="list-style-type: none"> Outpatient health care professional lab 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient health care professional diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/facility lab 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/facility diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient health care professional lab and diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient hospital/facility lab and diagnostic imaging 	100% of the allowed amount.
<p>NOTES:</p> <ul style="list-style-type: none"> Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. Court-ordered treatment for chemical dependency care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified chemical dependency assessor is deemed medically necessary. Court-ordered treatment for chemical dependency care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this Plan. 	

CHEMICAL DEPENDENCY (continued)

NOTES (continued):

- Court ordered treatment by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections.
- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services for chemical dependency that are not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- services to hold or confine a person under chemical influence when no medical services are required
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating chemical dependency or mental health conditions including, but not limited to: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter, shelter care and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition
- please refer to the “General Exclusions” section

CHIROPRACTIC CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Office visits from a doctor of chiropractic • Manipulations • Therapies • Other chiropractic services 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider • services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs • services for or related to therapeutic massage • services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized therapy to treat the member's condition • maintenance services • custodial care • please refer to the “General Exclusions” section 	

DENTAL CARE

The Plan Covers:	Benefit Payment
<p>This is not a dental plan. The following limited dental-related coverage is provided:</p> <ul style="list-style-type: none"> • Treatment from a physician or dentist for an accidental injury to sound and healthy natural teeth when performed within 12 months from the date of injury 	<p>If services apply to:</p> <p>Inpatient Services:</p> <p>You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.</p> <p>Medical Services:</p> <p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan. • The Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. • The Plan covers surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder on the same basis as any other body joint. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • dental services to treat an injury from biting or chewing • accident-related dental services performed more than 12 months after the date of injury • dental implants and prosthetics, including any related hospital charges • osteotomies and other procedures associated with the fitting of dentures or dental implants • any orthodontia, including associated orthognathic procedures or accident-related dental injuries • oral surgery and anesthesia for removal of impacted teeth and removal of a tooth root without removal of the whole tooth • root canal therapy • tooth extractions, unless otherwise specified as covered 	

DENTAL CARE (continued)

NOT COVERED (continued):

- any other dental procedure or treatment
- services, including dental splints, to treat bruxism
- please refer to the “General Exclusions” section

EMERGENCY CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Outpatient health care professional charges to treat an emergency medical condition as defined in Minnesota law 	100%
<ul style="list-style-type: none"> • Outpatient hospital/facility charges to treat an emergency medical condition as defined in Minnesota law 	100%
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • When determining if a situation is a medical emergency, we will take into consideration a reasonable layperson’s belief that the circumstances required immediate medical care that could not wait until the next business day. • For inpatient services, please refer to "Hospital Inpatient" and "Physician Services." • For urgent care visits, please refer to “Hospital Outpatient" and "Physician Services.” 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • please refer to the “General Exclusions” section 	

HOME HEALTH CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Skilled care and other home care services ordered by a physician and provided by employees of a Medicare or Plan approved home health care agency including, but not limited to: <ul style="list-style-type: none"> ▪ intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> ▪ licensed registered nurse ▪ licensed practical nurse ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietician ▪ services provided by a respiratory therapist ▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services of a home health aide or master's level social worker employed by the home health care agency when provided in conjunction with services provided by the above-listed agency employees ▪ use of appliances that are owned or rented by the home health agency 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • Benefits for home infusion therapy and related home health care are listed under “Home Infusion Therapy.” • For supplies and durable medical equipment billed by a Home Health Agency, please refer to “Medical Equipment, Prosthetics, and Supplies.” • Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other preapproved home health care agency consists of up to two (2) consecutive hours per date of service. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	

HOME HEALTH CARE (continued)

NOT COVERED:

- charges for or related to care that is custodial in nature (please refer to "Custodial Care," "Skilled Nursing Care – Intermittent Hours," "Skilled Nursing Care – Extended Hours," and "Skilled Care" in the "Definitions" section)
- treatment, services or supplies which are not medically necessary
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law (please refer to "Extended Hours Skilled Nursing Care" in the "Definitions" section)
- please refer to the "General Exclusions" section

HOME INFUSION THERAPY

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Home infusion therapy services, when ordered by a physician • Durable medical equipment • Ancillary medical supplies • Nursing services to: <ul style="list-style-type: none"> ▪ train you or your caregiver ▪ monitor the home infusion therapy • Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy • Other eligible home health services and supplies provided during the course of home infusion therapy 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • home infusion services or supplies not specifically listed as covered services • nursing services to administer home infusion therapy when the patient or another caregiver can be successfully trained to administer therapy • services that do not involve direct patient contact, such as delivery charges and record keeping • investigative or non-FDA approved drugs, except as required by law • please refer to the “General Exclusions” section 	

HOSPICE CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Hospice care for a terminal condition provided by a Medicare-approved hospice provider or other preapproved hospice including: <ul style="list-style-type: none"> ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Benefits are restricted to patients with a terminal condition (i.e., life expectancy of six (6) months or less). The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program. • Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time. • General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting. • Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit. • Two (2) or more episodes of hospice care will be considered one (1) episode unless separated by a period of at least three (3) months during which no hospice program is in effect for the individual. • You must agree to waive the standard benefits under the certificate, except when medically necessary because of an illness or injury unrelated to the terminal diagnosis. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • services you receive from a Nonparticipating Provider • room and board expenses in a residential hospice facility • please refer to the "General Exclusions" section 	

HOSPITAL INPATIENT

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Room and board up to 365 days and general nursing care • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription drugs and supplies used during a covered hospital stay • Lab • Diagnostic imaging 	<p>You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.</p>
<ul style="list-style-type: none"> • Communication services of a private duty nurse or a personal care assistant up to 120 hours per hospital admission 	<p>100% of the allowed amount. No deductible applies.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • The Plan covers kidney and cornea transplants. For kidney transplants done in conjunction with an eligible major transplant or other kinds of transplants, please refer to “Transplant Coverage.” • The Plan covers the following kidney donor services when billed under the donor recipient’s name and the donor recipient is covered for the kidney transplant under the Plan: <ul style="list-style-type: none"> ▪ potential donor testing; ▪ donor evaluation and work-up; and, ▪ hospital and professional services related to organ procurement. • The Plan covers anesthesia and inpatient hospital charges when necessary to provide dental to a covered person who is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. 	

HOSPITAL INPATIENT (continued)

NOTES (continued):

- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
 - Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
- Under federal law, the Plan may require that a provider obtain authorization from the Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- travel expenses for a kidney donor
- complications incurred by a kidney donor after the organ is removed
- kidney donor expenses when the recipient is not covered for the kidney transplant under this certificate
- communication services provided on an outpatient basis or in the home
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law
- please refer to the "General Exclusions" section

HOSPITAL OUTPATIENT

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Physical, occupational, and speech therapy • Lab • Diagnostic imaging • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Urgent care • Facility billed services received at a free-standing ambulatory surgical center • Prenatal care • All other eligible outpatient hospital care 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • The Plan covers anesthesia and outpatient hospital charges when necessary to provide dental to a covered person who is severely disabled or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. • The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 	

HOSPITAL OUTPATIENT (continued)

NOTES:

- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
 - Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
- Under federal law, the Plan may require that a provider obtain authorization from the Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- please refer to the "General Exclusions" section

MEDICAL EQUIPMENT, PROSTHETICS, AND SUPPLIES

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds • Devices for habilitative and rehabilitative services • Medical supplies, including splints, surgical stockings, casts, and dressings • Insulin pumps, glucometers and related equipment and devices not otherwise covered under the Medicare Part D program • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one (1) prosthesis per person per calendar year. • Diabetic supplies not otherwise covered under the Medicare Part D program: <ul style="list-style-type: none"> ▪ cotton balls ▪ alcohol swabs ▪ glucose test tablets ▪ lancets or other bloodletting devices ▪ other diabetic supplies • Custom foot orthoses if you have a diagnosis of diabetes with neurological manifestations of one or both feet • Amino acid-based elemental formula 	<p>100% of the allowed amount.</p>

MEDICAL EQUIPMENT, PROSTHETICS, AND SUPPLIES (continued)

<ul style="list-style-type: none"> Blood/urine test strips or syringes/needles which are purchased separately from insulin for SRCP Members who used such supplies between January 1, 1991 and September 30, 1991 (see Prescription Drugs, Section C.16) 	
<ul style="list-style-type: none"> Hearing aids, batteries and accessories are eligible if purchased through a provider or hearing aid supplier who participates with Blue Cross up to a benefit limitation of once every three (3) years 	80% of the allowed amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section.**
- Durable Medical Equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- Hearing aids and hearing aid evaluation tests, which are to determine the appropriate type of aid are covered up to a benefit limitation of once every three (3) years.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient’s medical condition.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the “Benefit Chart”
- personal and convenience items or items provided at levels which exceed our determination of medically necessary
- services or supplies that are primarily and customarily used for a nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants
- modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- blood pressure monitoring devices

MEDICAL EQUIPMENT, PROSTHETICS, AND SUPPLIES (continued)

NOT COVERED (continued):

- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- foot orthoses, except as provided in this "Benefit Chart"
- services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided in this "Benefit Chart"
- duplicate equipment, prosthetics, or supplies
- replacement of properly functioning durable medical equipment
- devices for maintenance services
- please refer to the "General Exclusions" section

MENTAL HEALTH CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> Outpatient health care professional charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/outpatient behavioral health facility charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient health care professional charges 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient hospital/ residential behavioral health facility charges for semi-private room up to 365 days 	You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.
<ul style="list-style-type: none"> Outpatient health care professional lab 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient health care professional diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/facility lab 	100% of the allowed amount.
<ul style="list-style-type: none"> Outpatient hospital/facility diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient health care professional lab and diagnostic imaging 	100% of the allowed amount.
<ul style="list-style-type: none"> Inpatient hospital/facility lab and diagnostic imaging 	100% of the allowed amount.
<p>NOTES:</p> <ul style="list-style-type: none"> Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, is deemed medically necessary. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this plan. 	

MENTAL HEALTH CARE (continued)

NOTES (continued):

- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Benefits are provided for autism treatment including intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services for mental illness not listed in the most recent edition of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating mental health or chemical dependency conditions including, but not limited to: custody evaluations, parenting assessments, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency and domestic violence programs
- room and board for foster care, group homes, shelter care, and lodging programs
- halfway house services
- court-ordered services that are not medically necessary
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars
- services for marriage/couples counseling
- educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- therapeutic day care and therapeutic camp services

MENTAL HEALTH CARE (continued)

NOT COVERED (continued):

- hippotherapy (equine movement therapy)
- please refer to the “General Exclusions” section

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Office visits from a physical therapist, occupational therapist, speech or language pathologist • Therapies • Office visits from a physician - see "Physician Services" 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • services primarily educational in nature, except as specified in the "Benefit Chart" • services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider • physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider • services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work-hardening programs, etc., and all related material and products for these programs • services for or related to therapeutic massage • services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized therapy for the member's condition • maintenance services • custodial care • please refer to the “General Exclusions” section 	

PHYSICIAN SERVICES

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Office visit for illness • Office visit for Urgent care services • E-Visit • Retail Health Clinic visit • Office and outpatient lab • Office and outpatient diagnostic imaging • Allergy testing, serum, and injections not otherwise covered under the Medicare Part D program • Eligible vaccines administered in the clinic (i.e., shingles, flu, etc.) • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization • Assistant surgeon • Medically necessary services of a Registered Nurse First Assistant • Bariatric surgery to correct morbid obesity including: <ul style="list-style-type: none"> ▪ anesthesia ▪ assistant surgeon • Kidney and cornea transplants • Hearing exams, audiometric tests, and audiologist evaluations which are provided by a participating Audiologist or Otolaryngologist • Palliative care • Prenatal care 	<p>100% of the allowed amount.</p>

PHYSICIAN SERVICES (continued)

NOTES:

- **Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section.**
- If more than one (1) surgical procedure is performed during the same operative session, Blue Cross covers the surgical procedures based on the allowed amount for each procedure. Blue Cross does not cover a charge separate from the surgery for pre-operative and post-operative care.
- Physician services includes services of an optometrist and an advanced practice nurse when performed within the scope of their licensure.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- You are entitled to receive care for the following services from providers who are not affiliated with Blue Cross:
 - the testing and treatment of a sexually transmitted disease; and,
 - the testing of AIDS or other HIV-related conditions.
- For kidney transplants done in conjunction with an eligible major transplant, please refer to “Transplant Coverage.”
- The Plan covers the following kidney donor services when billed under the donor recipient’s name and the donor recipient is covered for the kidney transplant under the Plan:
 - potential donor testing;
 - donor evaluation and work-up; and,
 - hospital and professional services related to organ procurement.
- The Plan covers certain routine patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- The Plan covers hearing aid exams/fitting/adjustments.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- E-Visit is a patient initiated, limited online evaluation and management service provided by a physician or other qualified health care Provider using the Internet or similar secure communications network to communicate with an established patient.
- A Retail Health Clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.

PHYSICIAN SERVICES (continued)

NOTES (continued):

- Under federal law, group health plans such as this Plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
 - Inpatient hospital coverage for the mother, if covered under this certificate, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this Plan. Refer to "Home Health Care."
- Under federal law, the Plan may require that a provider obtain authorization from the Plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit
- separate charges for pre-operative and post-operative care for surgery
- services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the "Benefit Chart"
- Provider initiated email communications
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- please refer to the "General Exclusions" section

PRESCRIPTION DRUGS AND INSULIN

Outpatient prescription drug coverage is provided through Group MedicareBlue Rx. Please refer to your MedicareBlue Rx information for details.

This health care plan does provide benefits for eligible drugs administered during a covered admission to an eligible inpatient facility when billed by that facility. Please refer to “Hospital Inpatient.”

PREVENTIVE CARE

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Preventive medical evaluation • Gynecological exams • Vision exams (glaucoma, acuity, refraction) • Cancer screening as specified below: <ul style="list-style-type: none"> ▪ mammograms ▪ pap smears ▪ flexible sigmoidoscopies and/or colonoscopies ▪ fecal occult blood testing ▪ Prostate Specific Antigen (PSA) tests, digital rectal exams ▪ surveillance tests for ovarian cancer (CA125 tumor marker, trans-vaginal ultrasound, pelvic exam) • Standard immunizations not otherwise covered under the Medicare Part D program • Hearing screening • Osteoporosis screening • Lab services as specified below: <ul style="list-style-type: none"> ▪ lipid profile, including total and HDL cholesterol ▪ diabetes screening ▪ screening for chlamydia, gonorrhea, syphilis and HIV 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Benefits for services identified as Preventive Care are determined based on recommendations and criteria established by professional associations and experts in the field of Preventive Care (e.g., Institute for Clinical Systems Improvement (ICSI), United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP)). • Eligible standard immunizations (e.g., diphtheria, tetanus) are covered under the Preventive Care benefit based on recommendations and criteria established by professional associations and experts in the field of Preventive Care. • Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Please refer to "Hospital Inpatient," "Hospital Outpatient," and "Physician Services" for appropriate benefit levels. 	

PREVENTIVE CARE (continued)

NOTES (continued):

- Benefits for physical exams are limited to one (1) per person per calendar year. Cancer screening services are not subject to the calendar year maximum.
- Benefits for gynecological exams are limited to one (1) per person per calendar year. Cancer screening services are not subject to the calendar year maximum.
- Benefits for hearing screening are limited to one (1) per person per calendar year.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

NOT COVERED:

- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request
- educational classes or programs
- services for or related to lenses, frames, contact lenses and other fabricated devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Benefit Chart"
- please refer to the "General Exclusions" section

RECONSTRUCTIVE SURGERY

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the body part • Elimination or maximum feasible treatment of port wine stains 	<p>100% of the allowed amount.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • Under the federal Women’s Health and Cancer Rights Act of 1998 and Minnesota law, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness. • For hospital/facility charges, please refer to "Hospital Inpatient" and "Hospital Outpatient." • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • repair of scars and blemishes on skin surfaces • please refer to the “General Exclusions” section 	

SKILLED NURSING FACILITY

The Plan Covers:	Benefit Payment
<ul style="list-style-type: none"> • Skilled care ordered by a physician • Room and board up to 365 days • General nursing care • Physical, occupational, and speech therapy 	<p>You are responsible for the \$200 annual deductible and 20% of the first \$3,000 of total eligible charges per calendar year. The Coordinated Plan then pays 100% of the remaining eligible charges less other coverage payments to the end of the calendar year.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the “Notification Requirements” section. • Skilled care ordered by a physician includes skilled care ordered by an optometrist, chiropractor, or advanced practice nurse when ordered within the scope of their licensure. • You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider. 	
<p>NOT COVERED:</p> <ul style="list-style-type: none"> • charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury • treatment, services or supplies which are not medically necessary • please refer to the “General Exclusions” section 	

TRANSPLANT COVERAGE

The Plan Covers:	Blue Distinction Centers for Transplant (BDCT) Providers	Non-Blue Distinction Centers for Transplant (BDCT) Providers
<p>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart-lung • Kidney-pancreas transplant performed simultaneously (SPK) • Liver - deceased donor and living donor • Lung - single or double • Pancreas transplant - deceased donor and living donor segmental <ul style="list-style-type: none"> ▪ Pancreas transplant alone (PTA) ▪ Simultaneous pancreas-kidney transplant (SPK) ▪ Pancreas transplant after kidney transplant (PAK) • Small-bowel and small-bowel/liver 	<p>100% of the Transplant Payment Allowance.</p> <p>Coordinated Plan deductible does not apply.</p> <p>If you live more than 50 miles from a BDCT Provider, there may be benefits available for expenses directly related to a preauthorized transplant.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p>	<p><i>Participating Transplant Provider</i></p> <p>80% of the allowed amount.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p> <p><i>Nonparticipating Transplant Provider</i></p> <p>NO COVERAGE.</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • Kidney transplants when not done in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Please refer to “Hospital Inpatient” and “Physician Services.” 		

TRANSPLANT COVERAGE (continued)

NOTES (continued):

- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota 55164 or faxed to 651-662-1624.

NOT COVERED:

- travel benefits when you are using a Non-BDTC Provider
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs and aftercare for or related to human organ transplants not specifically listed above as covered
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this Plan
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- please refer to the "General Exclusions" section

DEFINITIONS:

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

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

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatments, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.
3. Services that are normally provided without charge, including services of the clergy.
4. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while your coverage was in force.
5. Services for or related to therapeutic acupuncture except for treatment of chronic pain (defined as duration of at least six (6) months), or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
6. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim unless the worker's compensation carrier has disputed the claim.
7. Charges that are eligible, paid or payable, under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
8. Services a provider gives to himself/herself or to a close relative (such as a spouse, brother, sister, parent, grandparent, and/or child).
9. Services for or related to treatment of illness or injury which occurs while on military duty that are recognized by the Veteran's Administration as services related to service-connected illnesses/injuries.
10. Charges for services for dependents. This is individual coverage only.
11. Services that are prohibited by law or regulation.
12. Services which are not within the scope of licensure or certification of a provider.
13. Charges for furnishing medical records or reports and associated delivery charges.
14. Services for or related to transportation, other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the "Benefit Chart."
15. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the "Benefit Chart."
16. Services for or related to chemical dependency or addictions that are not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

17. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.
18. Evaluations that are not performed for the purpose of diagnosing or treating chemical dependency or mental health conditions including, but not limited to: custody evaluations, parenting assessments, education classes, classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.
19. Services for or related to room and board for foster care, group homes, shelter, shelter care, incarceration and lodging programs, halfway house services, and skills training.
20. Charges made by a health professional for physician/patient telephone consultations.
21. Services for or related to chemical dependency interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition.
22. Dentures, regardless of the cause or condition, and any associated services and/or charges, including bone grafts.
23. Dental implants and prosthetics including any associated services and/or charges.
24. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the "Benefit Chart."
25. Services, including dental splints, to treat bruxism.
26. Room and board expenses in a residential hospice facility.
27. Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy. Services that do not involve direct patient contact such as delivery charges and recordkeeping.
28. Admission for diagnostic tests that can be performed on an outpatient basis.
29. Service for or related to extended hours skilled nursing care, also referred to as private-duty nursing care, except as required by Minnesota law.
30. Personal comfort items, such as telephone, television, etc.
31. Communication services provided on an outpatient basis or in the home.
32. Services for or related to sex transformation/gender reassignment surgery, sex hormones related to the surgery, related preparation and follow-up treatment, or care and counseling, unless medically necessary as determined by us prior to receipt of the services.
33. Services for or related to reversal of sterilization.

34. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the "Benefit Chart."
35. Services or supplies that are primarily and customarily used for nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants.
36. Modifications to home, vehicle and/or the workplace, including vehicle lifts and ramps.
37. Blood pressure monitoring devices.
38. Service for or related to foot orthoses, except as specified in the "Benefit Chart."
39. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
40. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the "Benefit Chart."
41. Services for or related to mental illness not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
42. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); the treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).
43. Services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.
44. Services for or related to marriage/couples counseling.
45. Services primarily educational in nature, except as specified in the "Benefit Chart."
46. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.
47. Physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.

48. Services for or related to health clubs and spas.
49. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of a specialized therapy for the member's condition.
50. Maintenance services.
51. Custodial care.
52. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages), educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting), or forms of nonmedical self-care or self-help training, including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
53. Service for or related to therapeutic massage.
54. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
55. Services for or related to the repair of scars and blemishes on skin surfaces.
56. Internet or similar network communications for the purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
57. Provider initiated email communications.
58. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
59. Services for or related to growth hormone except that replacement therapy is eligible for conditions that meet medical necessity criteria as determined by us prior to receipt of the services.
60. Autopsies.
61. Charges for failure to keep scheduled visits.
62. Charges for giving injections which can be self-administered.
63. Services for or related to tobacco cessation program fees and/or related program supplies.

64. Services for or related to commercial weight loss programs, fees or dues, nutritional supplements, food, vitamins and exercise therapy, and all associated labs, physician visits, and services related to such programs.
65. Treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy or chelation therapy that are not medically necessary.
66. Nonprescription (over-the-counter) and outpatient drugs or medicines, except as specified in the "Benefit Chart;" vitamin therapy or dietary supplements; and investigative or non-FDA approved drugs.
67. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.
68. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the "Benefit Chart."
69. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
70. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.
71. Services for or related to fetal tissue transplantation.
72. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this certificate; and kidney donor expenses when the recipient is not covered under this certificate.
73. Services for or related to preservation and storage of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and, any other human tissue, except as specified in the "Benefit Chart."

ELIGIBILITY

The Minnesota Management and Budget (MMB) determine the eligibility subject to collective bargaining agreements, which may change during a benefit year. Blue Cross agrees to accept the decisions of the MMB as binding. This is individual only coverage.

Effective Date of Coverage

The effective date of coverage is determined by the MMB.

Termination of Coverage

Coverage ends on the earliest of the following dates:

1. the end of the month in which either Blue Cross or the MMB terminates the Contract;
2. the end of the month in which eligibility under the Contract ends; or,
3. the end of the month for which the last full premium was paid, when the member fails to pay the premium within 30 days of the date the premium is billed or is due, whichever is later.

Extension of Benefits

If you are confined as an inpatient on the date your coverage ends due to the replacement of the group contract, we automatically extend coverage until the date you are discharged from the facility or the date contract maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the group contract terminates and the group contractholder obtains continuous group coverage with a new carrier.

Off-Cycle Enrollment Without Evidence of Insurability

A member will be allowed to make an enrollment choice outside of the open enrollment period or initial period of eligibility without evidence of insurability under any of the circumstances specified below. Decisions as to whether these circumstances occur are at the sole discretion of the MMB and are binding on Blue Cross.

1. Any carrier participating in the State Employee Group Insurance Program is placed into rehabilitation or liquidation, or is otherwise unable to provide the services specified in the certificate and/or benefit booklet.
2. Any carrier participating in the State Employee Group Insurance Program loses all or a portion of its primary care provider network (including hospitals) to the extent that services are not accessible or available within thirty miles of the work station, including withdrawal from an approved service area.

3. The Carrier participating in the State Employee Group Insurance Program terminates or is terminated from participation in the Program.
4. The MMB approves a request from an employee or an agency due to a breakdown in the open enrollment process.
5. A member may elect to designate another carrier in the 60-day time period immediately preceding the effective date of retirement.
6. As otherwise specified by the MMB.

COORDINATION OF BENEFITS

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

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
 - a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage (group coverage is always primary and pays first);
 - b. coverage under a government plan or one required or provided by law; or,
 - c. individual coverage.

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

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

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

2. "This Plan" means the part of the Plan that provides health care benefits.
3. "Primary plan/secondary plan" is determined by the Order of Benefits Rules.

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

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

Notes:

- a. If you are covered under This Plan and Medicare: This Plan will comply with the Medicare Secondary Payor ("MSP") provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. Medicare will be primary and this Plan will be secondary only to the extent permitted by MSP rules.

- b. If you are covered under This Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a Primary Plan and which is a Secondary Plan. TRICARE will be primary and This Plan will be secondary only to the extent permitted by TRICARE rules.
4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this Plan.

The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under this Plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

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

Order of Benefits Rules

1. General. When a claim is filed under this Plan and another plan, this Plan is a secondary plan and determines benefits after the other plan, unless:
 - a. the other plan has rules coordinating its benefits with this Plan's benefits; and,
 - b. the other plan's rules and this Plan's rules, in part b. below, require this Plan to determine benefits before the other plan.
2. Rules. This Plan determines benefits using the first of the following rules that applies:
 - a. Active/inactive employee. The plan that covers a person as an employee who is neither laid off nor retired determines benefits before a plan that covers that person as a laid-off or retired employee. If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
 - b. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for the shorter time.

Effect on Benefits of This Plan

1. When this section applies.

When the Order of Benefits Rules above requires this Plan to be a secondary plan, this part applies. Benefits of this Plan may be reduced.

2. Reduction in this Plan's benefits.

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

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

If you are eligible to have Medicare pay as your primary health plan, payment under This Plan will be reduced by the amounts Medicare Parts A and B paid or would have paid for covered services.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. Blue Cross has the right to decide which facts are needed. Blue Cross may get needed facts from, or give them to, any other organization or person as necessary to coordinate benefits under this certificate. Blue Cross does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Blue Cross any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If this happens, Blue Cross may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. Blue Cross will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If Blue Cross pays more than it should have paid under these coordination of benefit rules, it may recover the excess from any of the following:

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

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

REIMBURSEMENT AND SUBROGATION

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

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

Duty to Cooperate

You must cooperate with Blue 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.

GENERAL PROVISIONS

Filing a Claim and Review Procedure

In-Network providers file your claims for you. If you use an Out-of-Network provider, however, you may have to file the claim yourself. If you notify us of a claim we will send you a claim form within 15 days. Claim forms are also available by calling the toll-free Customer Service telephone number listed in the Customer Service section and on our website at www.bluecrossmn.com. You can also write us at the address listed in the Customer Service section. You must file a written claim within 30 days after a covered service is provided. If this is not reasonably possible, we accept claims for up to 12 months after the date of service. Normally, failure to file a claim within the required time limits will result in denial of your claim. We waive these limits, however, if you cannot file the claim because you are legally incapacitated. You may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that you have incurred a covered expense that is eligible for reimbursement.

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

Right of Examination

Blue Cross has the right to ask you to be examined by a provider during the review of any claim. Blue Cross will choose the provider and pay for any such exam. Failure to comply with this request may result in denial of your claim.

Release of Records

By your application, you have agreed to allow all providers to give us needed information about the care they provide to you. We may need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but we may release it if you authorize release, or if state or federal law permits or requires release without your authorization. If a provider requires special authorization for release of records, you agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of your claim.

Entire Contract

This Certificate, the ID card, application, and the group contract make up the entire Contract of Coverage. You may ask to see the Group Contract at the Employer's office. Blue Cross has discretionary authority to determine your eligibility for benefits and to construe the provisions of the Contract and this certificate. 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 application. This certificate 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.

Time Limit for Misstatements

If there is any misstatement in the written application you complete, Blue Cross 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 (2) years or more from the initial date of coverage issued as a result of that application. This time limit does not apply to fraudulent misstatements.

Changes to the Group Contract

All changes to the Group Contract must be approved by MMB and attached to the Group Contract. No agent can legally change the Group Contract or waive any of its terms.

In applying any Deductible or waiting period, Blue Cross gives credit for the full or partial satisfaction of the same or similar provisions under the prior contract.

Whom We Pay

When you receive Covered Services from Participating Providers, Blue Cross pays the Provider directly. When you receive Covered Services from a Nonparticipating Provider, Blue Cross pays you. You may not assign your benefits to a Nonparticipating Provider. This provision may be waived for: ambulance providers in Minnesota and border counties of contiguous states; and certain out-of-state institutional and medical/surgical providers. You also may not assign your right, if any, to commence legal proceedings against Blue Cross.

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), except for medical emergency services when payment of such services are authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third-Party Beneficiaries

The benefits described in this Plan are intended solely for your benefit. No one else may claim to be a third-party beneficiary of this Plan. No one other than you may bring a lawsuit, claim or any other cause of action related in any way to this Plan, and you may not assign your rights to any other person.

Legal Actions

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

Claim Appeals

The Explanation of Benefits form you receive when a claim has been processed explains how your claim was processed based upon the information made available to Blue Cross. If all, or a part, of the claim has been denied, you will find the reason for denial listed at the bottom of the front side of the form. If you disagree with the action taken on your claim and wish to appeal that action, please follow these steps:

1. Call Blue Cross at one of the telephone numbers listed in the "Customer Service" section.
2. If you are not satisfied with the explanation given, send a letter to Blue Cross asking them to reconsider your claim. Please include your subscriber identification number and the claim number from the front of the Explanation of Benefits.
3. The letter must be received within 60 days after you are notified of the claim resolution. Attach to Your letter any additional information that will help support your reason for appealing the claims processing action.
4. Blue Cross will make a final decision about your claim within 60 days after they receive your letter. If, due to external delays beyond their control, they cannot make a final decision within 60 days, they will send you written notification. Examples of such external delays are when Blue Cross needs to obtain medical records or refer your case for review by a medical consultant.
5. In some cases, Blue Cross may need to have their medical consultants review your claim. If a Provider disagrees with the consultants, the Blue Cross Medical Director will review your claim with the help of a committee or appropriate medical professionals who will make the final decision.

Plan Change

Nothing in the contract between the state of Minnesota and Blue Cross shall modify, limit or restrict the authority of the Commissioner of MMB as permitted by law to enter into contracts with other carriers or Providers; to remove a health plan from the State Employee Group Insurance Program; and to limit the geographic area serviced by the health plan covering members under the State Employee Group Insurance Program.

Payment of Premiums

Premiums for your coverage must be prepaid.

We have the right to change the rate for all contracts like yours and will notify you in advance of any changes.

Grace Period

After your first payment of premiums, we allow a 31-day grace period for payment. The grace period starts on the day after the due date for payment. You are covered during this grace period provided payment of premiums is made by the end of the grace period. If we do not receive payment by the end of the grace period, your contract lapses retroactively to the date to which coverage has been paid.

COMPLAINT PROCESS

Introduction

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

If your complaint concerns a covered health care service or claim, you may request an external review of the final decision we make about your appeal after you have exhausted the Blue Cross appeal process.

In addition, you may file your complaint with the Minnesota Commissioner of Commerce at any time by calling 651-296-4026 or toll-free 1-800-657-3602.

Definitions

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

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

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

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

Process for Complaints that do not Require a Medical Determination

Verbal Notification

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

Written Notification

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

Blue Cross will notify you that we have received your written complaint.

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

Appeal

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

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

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

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

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

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

External Review

If your complaint concerns a health care service or claim and you believe Blue Cross' appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf, may submit the adverse determination to external review. You may submit an adverse determination to external review at any time and are not required to use Blue Cross' voluntary appeal process first. External review of your complaint will be conducted by an independent organization under contract with the state of Minnesota. The written request must be submitted to the Minnesota Commissioner of Commerce along with a filing fee. The Commissioner may waive the fee in cases of financial hardship.

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
Suite 500
85 7th Place East
St. Paul, Minnesota 55101-2198

The external review entity will notify you and Blue Cross that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and Blue Cross must provide the external review entity and information to be considered. Both you and Blue Cross will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you. Blue Cross, and the commissioner within 40 days of receiving the request for external review. The external review entity's decision is binding on Blue Cross, but not binding on you.

Process for Complaints When Utilization Review is Necessary

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

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

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

Definitions

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

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

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

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

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

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

Determinations

Standard review determination

When a medical determination is required, Blue Cross' initial determination will be communicated to you and your provider with in 10 business days of the request provided that all information reasonably necessary to make a determination on your request has been made available to us.

When we authorize services, we notify the provider by telephone and in writing. When we determine not to authorize the services, we notify the attending health care professional and hospital by telephone, and notify the attending health care professional, hospital, and enrollee in writing. Notification will include notice of the right to appeal and how to submit an appeal.

Expedited review determination

Blue Cross will use an expedited review determination if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, we will notify the attending health care professional, hospital and enrollee of the decision as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. If the expedited determination is to not authorize services, notification will include notice that you and your attending health care professional may submit an expedited appeal, and how to submit an expedited appeal.

Appeals

Standard appeal

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

The request for appeal should include:

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

Expedited appeal

When Blue Cross does not authorize services under the expedited review determination procedure described above, and the attending health care professional believes that an expedited appeal is warranted, you and your attending health care professional may request an expedited appeal. You and your attending health care professional may appeal the determination over the telephone. Our appeal staff will include the consulting physician or health care provider if reasonably available. When an expedited appeal is completed, we will notify you and your attending health care professional of the decision as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from our receipt of the expedited appeal request.

External Review

If the standard or expedited appeal determination is to not authorize services, you or your attending health care professional may request external review as described above.

This complaint process is subject to change if required or permitted by changes in state or federal law governing complaint procedures.

DEFINITIONS

Please refer to the Benefit Chart for specific benefits and payment information.

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

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

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

Allowed Amount The amount that payment is based on for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the “Benefit Chart.”

For Participating Providers, the allowed amount is the negotiated amount of payment that the Participating Provider has agreed to accept as full payment for a covered service at the time your claim is processed. We periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating Providers for certain covered services may not be based on a specified charge for each service, and we use a reasonable allowance to establish a per-service allowed amount for such covered services. Through annual or other global settlements, rebates, prospective payments, or other methods, we may adjust the amount due to Participating Providers without reprocessing individual claims. These adjustments will not cause any change in the amount you paid at the time your claim is processed. If the payment to the provider is decreased, the amount of the decrease is credited to us, and the percentage of the allowed amount paid by us is lower than the stated percentage for the covered service. If the payment to the provider is increased, we pay that cost on your behalf, and the percentage of the allowed amount paid by us is higher than the stated percentage.

Qualifications Applicable to All Nonparticipating Providers

For Nonparticipating Providers, the Allowed Amount is determined by the provider type, provider location, and the availability of certain pricing methods. The Allowed Amount may not necessarily be based upon or related to a usual, customary or reasonable charge. The Plan will pay the stated percentage of the Allowed Amount for a Covered Service. In most cases, the Plan will pay this amount to you. The determination of the

Allowed Amount is subject to all business rules as defined in our Provider Policy and Procedure Manual. As a result, we may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The Allowed Amount for Nonparticipating Providers in Minnesota

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

The Allowed Amount for All Nonparticipating Provider Services outside Minnesota

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

Special Circumstances

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

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

Attending Health Care Professional	A health care professional with primary responsibility for the care provided to a sick or injured person.
Audiologist	A person who has a certificate of clinical competence in audiology from the American-Speech-Language-Hearing Association.
Audiologist Evaluation	A hearing test and an assessment by a licensed audiologist or otolaryngologist of communication problems caused by hearing loss.
Average Semiprivate Room Rate	The average rate charged for semiprivate rooms. If the Provider has no semiprivate rooms, we use the average private room rate for payment of the claim.
Behavioral Health Network Provider	A health care professional that participates in a special network for the provision of mental health or chemical dependency treatment services.
Benefit Chart	The schedule that lists benefit and covered services.
Calendar Year	The period starting on January 1 st of each year and ending at midnight December 31 st of that year.
Care/Case Management Plan	A plan for health care services developed for a specific patient by one of our care/case managers after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain optimal health status.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.
Certification of Coverage	A form which will be issued when health coverage is terminated under the certificate. This Certification of Coverage form will contain the necessary information a new health plan will need to apply the appropriate credit toward the new health plan's preexisting condition limitation period.
Chemical Dependency	Alcohol or drug dependence as defined in the <i>International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)</i> .

Claim

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

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

Claims Administrator

Blue Cross and Blue Shield of Minnesota (Blue Cross).

Coinsurance

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

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

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

Coinsurance Example:

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

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over Blue Cross' allowed amount when a Nonparticipating Provider is used.

For example, if a Nonparticipating Provider ordinarily charges \$100 for a service, but Blue Cross' allowed amount is \$95, Blue Cross will pay 80% of the allowed amount (\$76). You must pay the 20% coinsurance on the Blue Cross' allowed amount (\$19), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$24.

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

Comprehensive Pain Management Program

A multidisciplinary program including, at a minimum, the following components:

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

Coordinated Plan Deductible

The amount you must pay toward the allowed amount for certain covered services each benefit year before Blue Cross begins to pay benefits. Deductibles are shown in the Benefit Chart.

Cosmetic Surgery

Surgery and other cosmetic health services which are chiefly intended to improve appearance and are not medically necessary as determined by Blue Cross.

Covered Services

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

Custodial Care

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

Deductible

The amount you must pay toward the allowed amount for certain covered services each year before we begin to pay benefits. The deductible is the same as the Coordinated Plan deductible. The deductibles for each person and family are shown on the Benefit Chart.

Your coinsurance and deductible amount will be based on the negotiated payment amount Blue Cross has established with the provider or the provider's charge, whichever is less.

The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides.

Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements Blue Cross may receive from other parties.

Durable Medical Equipment	Medical equipment prescribed by a physician that meets each of the following requirements: <ol style="list-style-type: none">1. able to withstand repeated use;2. used primarily for a medical purpose;3. generally not useful in the absence of illness or injury;4. determined to be reasonable and necessary; and,5. represents the most cost-effective alternative.
Enrollment Date	The first day of coverage, or if there is a waiting period, the first day of the waiting period (typically the date employment begins).
E-Visit	A patient initiated, limited online evaluation and management health care service provided by a physician or other qualified health care Provider using the Internet or similar secure communications network to communicate with an established patient.
Facility	A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, a home health agency, or freestanding birthing center when services are billed on a facility claim.
Foot Orthoses	Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity; protect against injury; or assist with function. Foot orthoses generally refer to orthopedic shoes and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom-made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.
Freestanding Ambulatory Surgical Center	A provider that facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, a clinic, a doctor's office, or other health care professional's office.

Group Contractholder	The employer or association to which the group contract is issued.
Group Member	The member for whom coverage has been provided by the group contractholder or association.
Habilitative Services	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.
Health Care Professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, occupational and speech therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
Hearing Aid	A monaural hearing aid, set of binaural hearing aids, or other device worn by the recipient to improve access to and use of auditory information.
Hearing Aid Accessory	Chest harness, tone and ear hooks, carrying cases, and other accessories necessary to use the hearing aid, but not included in the cost of the hearing aid.
Home Health Agency	A Medicare-approved facility that sends health professionals and home health aides into a person's home to provide health services.
Hospice Care	A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals suffering from a terminal disease or condition.
Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Illness	A sickness, injury, pregnancy, mental illness, chemical dependency, or condition involving a physical disorder.
Investigative	A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We base our decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

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

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

**Lifetime
Maximum**

The cumulative maximum payable for covered services incurred by you during your lifetime under this Plan. The lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copays, penalties and other amounts. Refer to the Benefit Chart for specific dollar maximums on certain services.

**Maintenance
Services**

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

**Medical
Emergency**

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

Medically Necessary	Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
Medicare	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.
Mental Health Care Professional	A psychiatrist, psychologist, independent social worker, licensed professional counselor, marriage and family therapist, or clinical nurse specialist licensed for independent practice that provides treatment for mental disorders.
Mental Illness	A mental disorder as defined in the <i>International Classification of Diseases (ICD)</i> and <i>Diagnostic and Statistical Manual for Mental Disorders (DSM)</i> . Mental disorder does not include alcohol or drug dependence, nondependent abuse of drugs, or mental retardation.
Nonparticipating Provider	A provider that has not entered into a network contract with us or the local Blue Cross and/or Blue Shield Plan.
Otolaryngologist	A physician specializing in diseases of the ear and larynx who is certified by the American Board of Otolaryngology or eligible for board certification.

Out-of-Pocket Maximum	The most each person must pay each calendar year toward the allowed amount for certain covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for certain covered services for that person for the rest of the calendar year. The "Benefit Chart" lists the out-of-pocket maximum amounts.
Outpatient Behavioral Health Treatment Facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, chemical dependency, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient Care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative Care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Participating Provider	A provider who has entered into a network contract with us or the local Blue Cross and/or Blue Shield Plan.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
Place of Service	Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers. Providers use different types of claim forms to bill for services based on the "place of service." Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different that diagnostic imaging delivered in an outpatient setting.
Plan	The Plan of benefits established by the plan administrator.
Provider	A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered to provide the health services billed by that provider and a health care facility licensed under law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also includes home health agencies.

Rehabilitative Services	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.
Residential Behavioral Health Treatment Facility	A facility licensed under state law in the state in which it is located that provides inpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, chemical dependency or drug addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite Care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
Retail Health Clinic	A clinic, also referred to as a convenience clinic, located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail Health Clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the Retail Health Clinic. Access to Retail Health Clinic services is available on a walk-in basis.
Services	Health care services, procedures, treatments, durable medical equipment, medical supplies, articles and prescription drugs.
Skilled Care	Services rendered other than in a Skilled Nursing Facility that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the Plan.

Skilled Nursing Care – Extended Hours	<p>Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member’s home.</p> <p>Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.</p>
Skilled Nursing Care – Intermittent Hours	<p>Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member’s home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.</p>
Skilled Nursing Facility	<p>A Medicare-approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.</p>
Social Security Disability	<p>Total disability as determined by Social Security.</p>
Supervised Employees	<p>Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.</p>
Supply	<p>Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury, or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.</p> <p>Supplies do not include such things as:</p> <ol style="list-style-type: none"> 1. alcohol swabs; 2. cotton balls; 3. incontinence liners/pads; 4. Q-tips; 5. adhesives; or, 6. informational materials.
Terminally III Patient	<p>An individual who has a life expectancy of six (6) months or less, as certified by the person’s primary physician.</p>

Treatment

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

Value-Based Program

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

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