



**BlueCross BlueShield  
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association

# Insta-Care

## Individual Comprehensive Major Medical Contract

**THIS IS A NON-QUALIFIED PLAN.**

**THIS IS A LIMITED CONTRACT.  
PLEASE READ IT CAREFULLY.**

### **RIGHT TO CANCEL**

You may cancel this contract by delivering or mailing a written notice or sending a telegram to Blue Cross and Blue Shield of Minnesota, 1800 Yankee Doodle Rd., Eagan, MN 55122, P. O. Box 64560, St. Paul, Minnesota 55164. In addition, you must return the contract before midnight of the tenth day after the date you receive the contract. All materials must be properly addressed and postage prepaid. Blue Cross and Blue Shield of Minnesota must return all payments made for this contract within 10 days after receiving notice of cancellation and the returned contract. This agreement is a legal agreement between the contractholder and Blue Cross and Blue Shield of Minnesota.

This contract does not provide benefits for any preexisting conditions. A preexisting condition is any injury, illness or condition for which you or your eligible dependent have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract. A pregnancy existing any time prior to the effective date of your coverage is considered a preexisting condition.

This health care coverage is limited to 30, 60, or 90 days depending on the amount of time you selected on your application.

A handwritten signature in black ink, appearing to read "Mark W. Smith".

President

The Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans.

® Registered Servicemark of Blue Cross and Blue Shield Association

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



# INDEPENDENT CORPORATION

Subscriber and covered dependents hereby expressly acknowledge their understanding this agreement constitutes a contract solely between Subscriber and BCBSM, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSM to use the Blue Cross and Blue Shield Service Marks in the State of Minnesota, and that BCBSM is not contracting as the agent of the Association. Subscriber and covered dependents further acknowledge and agree that they have not entered into agreement based upon representations by any person other than BCBSM and that no person, entity, or organization other than BCBSM shall be accountable or liable to Subscriber and covered dependents for any of BCBSM's obligations to Subscriber and covered dependents created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSM other than those obligations created under the provisions of this agreement.

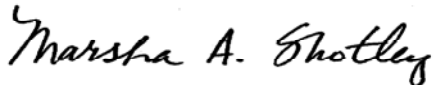
## ACCEPTANCE OF THE CONTRACT

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

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



*Mark Banks*  
President and CEO



*Marsha A. Shotley*  
Assistant Secretary



# ANNUAL NOTIFICATIONS

## ***General Provider Payment Methods***

Several 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) Provider Payment**

**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 provider is paid on a discounted fee-for-service basis, but no portion of the provider’s payment is withheld.

### **Institutional (i.e., hospital and other facility) Provider Payment**

#### **Inpatient Care**

**Payments for each Case (case rate)** – Providers are paid a fixed amount based upon the member’s diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis (“outlier payment”). This method is similar to the payment methodology used by the federal government to pay providers for Medicare services.

**Payments for each Day (per diem)** – Providers are paid a fixed amount for each day the patient spends in the hospital or facility.

**Percentage of Billed Charges** – Providers are paid a percentage of the hospital’s or facility’s billed charges for inpatient or outpatient services, including home services.

## **Outpatient Care**

**Payments for each category of services** – Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.

**Payments for each visit** – Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.

**Payments for each patient** – Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

## **Out-of-Service-Area Professional and Institutional Payments**

Out-of-service-area professional and institutional providers are usually paid according to the provider's contract with their local Blue Cross and Blue Shield plan. If the professional provider or institution does not contract with their local Blue Cross and Blue Shield plan, the provider is paid a percentage of the billed charges or other negotiated amount.

## **Pharmacy Payment**

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

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

## **Nonparticipating Provider Payments**

"Nonparticipating" providers are not under provider contract and are paid according to the member's contract. The payment method may be based on a percentage of the provider's billed charge, a negotiated amount, or a discounted fee-for-service.

*We feature a large network of providers. Each provider is an independent contractor and is not our agent.*

*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.



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## INTRODUCTION

For purposes of this contract, “you” or “your” refers to the contractholder named on the identification (ID) card and other covered dependents. Contractholder is the person for whom we have provided coverage. Dependent is a covered dependent of the contractholder. “We,” “us,” and “our” refer to Blue Cross. Other terms are defined in the “Definitions” section.

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

Coverage under this contract for eligible members and dependents will begin as defined on the Contract Schedule and Application, “Benefit Chart” or in the “Eligibility” section.

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

This contract provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use In-Network Providers. In-Network Providers are providers that have entered into a service agreement with us to provide you quality health services at favorable prices. Please refer to your Provider Directory for a listing of In-Network Providers.

This contract also provides benefits for covered services you receive from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers are also referred to as Nonparticipating Providers. Nonparticipating Providers have not entered into a service agreement with us. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

All coverage for dependents and all references to dependents in this contract are inapplicable for single coverage.

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

## CUSTOMER SERVICE

**Questions?**

Our customer service staff is available to answer questions about your coverage and direct your calls for preadmission and emergency admission notification.

Monday through Thursday: 8:00 a.m. - 4:30 p.m. Central Time  
Friday: 9:00 a.m. - 4:30 p.m. Central Time

*Hours are subject to change without prior notice.*

**Customer Service Telephone**

651-662-5030 or toll-free at 1-800-531-6685  
Fax 651-662-2906

**Blue Cross and Blue Shield of Minnesota Website**

<http://www.bluecrossmn.com>

**BlueCard Telephone Number**

Toll free 1-800-810-BLUE (2583)  
This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.

**BlueCard Website**

<http://www.bcbs.com>

This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.

**Office Address**

You may visit our Home Office during normal business hours:

Blue Cross and Blue Shield of Minnesota  
RiverPark II  
1800 Yankee Doodle Rd.  
Eagan, MN 55122

**Mailing Address**

Claims review requests and written inquiries may be mailed to the address below:

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

Prior authorization requests should be mailed to the following address:

Blue Cross and Blue Shield of Minnesota  
Medical Review Department  
P.O. Box 64265  
St. Paul, MN 55164

**Behavioral Health Network Telephone Number**

Toll free 1-800-469-1110  
This number is used to direct you to a Behavioral Health Network Provider.

### ***Choosing a Health Care Provider***

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

#### **In-Network Providers**

In-Network Providers are also known as Participating Providers. When you choose these providers, you get the most benefits for the least expense and paperwork. These providers will take care of any notification requirements and send your claims to us and we send payment to the provider for covered services you receive. The provider directory lists In-Network Providers and may change as providers enroll or terminate their agreements. For benefit information on these providers, refer to the "Benefit Chart."

#### **Out-of-Network Providers**

Out-of-Network Providers are also known as 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 In-Network Providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles;
2. coinsurance;
3. charges that exceed the benefit maximum;
4. charges for services that are not covered; and
5. charges for services that are investigative or not medically necessary if you are notified in writing before you receive services that they 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 service agreement 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;
3. coinsurance;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that we determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary.

If you or the provider fail to contact us for prior authorization or preadmission notification, your benefits may be reduced and you could pay additional charges.

## ***BlueCard<sup>®</sup> Program***

### **Liability Disclosure**

When you obtain health care services through the BlueCard Program outside the geographic area BCBSM serves, the amount you pay for covered services is calculated on the **lower** of:

1. the billed charges for your covered services; or
2. the negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes on to us.

Often, this “negotiated price” consists of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, the negotiated price is either 1) an estimated price that factors expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers into the actual price; or 2) billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will be prospectively adjusted to correct for over- or underestimation of past prices. The amount you pay, however, is considered a final price and will not be affected by the prospective adjustment.

Statutes in a small number of states may require the Host Blue either 1) to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim; or 2) to add a surcharge. If any state statutes mandate liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, BCBSM will calculate your liability for any covered health care services according to the applicable state statute in effect at the time you received your care.

### ***Recommendations by Health Care Providers***

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

### ***Fraudulent Practices***

Coverage for you or your dependents will be terminated if you or your dependent: falsify medical history on the application for coverage; submit fraudulent, altered, or duplicate billings for personal gain; and/or allow another party not covered under the contract to use your or your dependent’s 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. and ends at 12:00 a.m. the following day.

### ***Medical Policy Committee***

Our Medical Policy Committee determines whether new or existing medical treatment 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.

## NOTIFICATION REQUIREMENTS

### ***Prior Authorization***

We review all services to verify that they are medically necessary and that the treatment provided is the proper level of care. Prior authorization from us is recommended before you receive selected services so that you avoid incurring charges for services that may not be considered medically necessary. In-Network Providers will obtain prior authorization for you.

**If you are using a provider that does not participate with us, you are responsible for obtaining prior authorization. We recommend 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.

With prior authorization, BCBSM guarantees payment for services BCBSM approved in advance if your policy is in force the date you receive care, you have not exceeded your lifetime or benefit maximum, the condition is not subject to a preexisting condition limitation period, and the procedure that is authorized is the service that is billed by the provider. All applicable exclusions, deductibles, copays, and coinsurance provisions continue to apply. While all services must be medically necessary, prior authorization is recommended for certain services. This list is subject to change due to changes in medical policy. The most current list is available by calling Customer Service.

1. Acupuncture
2. Bariatric surgery, (all procedures)
3. Chiropractic care
4. Drugs, including, but not limited to the following:
  - a. Alefacept (Amevive)
  - b. Factor products for the treatment of bleeding disorders
  - c. Growth hormones
  - d. Intravenous immune globulin (IVIG)
  - e. Leuprolide acetate (Lupron) (all uses except for cancer-related diagnoses)
5. Durable Medical Equipment (DME), including, but not limited to the following:
  - a. All unlisted DME over \$1,000
  - b. Any devices where there may be a question if the definition of DME is met or where unlisted codes will be submitted
  - c. Bone growth stimulators
  - d. Hearing devices (all types) for children under age 18
  - e. Home prothrombin time monitors
  - f. Specialty beds
  - g. Vest percussors
  - h. Wound healing treatment/devices
6. Home health services
7. Physical therapy, occupational therapy, and speech therapy for multiple sclerosis or for children under age 10 with cerebral palsy when services are received from a Participating Provider or for all services received from a Nonparticipating Provider
8. Temporomandibular joint/ craniomandibular disorder surgery and temporomandibular joint arthroscopy
9. Transplants:
  - a. Autologous islet cell transplants
  - b. Organ transplant procedures
  - c. Stem cell and bone marrow procedures

**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 requests.**

## ***Preadmission Notification***

Preadmission notification is required at least five (5) days in advance of being admitted for inpatient care for any type of nonemergency service. In-Network Providers will provide preadmission notification to us for you. With preadmission notification, we guarantee payment for days or services we authorize if the services are otherwise covered under this contract, and you are covered on the date you receive the services.

**If you are going to receive nonemergency care from a Nonparticipating Provider, you are responsible for providing preadmission notification to us.**

If we are not notified of your admission to a Nonparticipating Provider, a penalty will apply. We will reduce the allowed amount for the admission by 25 percent before applying deductibles or copays. This means that without preadmission notification, you will pay a greater portion of the charges. If preadmission notification is not provided and services are later determined not to be medically necessary, you are also responsible for payment of those charges.

Preadmission notification is required for the following facilities:

1. Hospitals;
  - a. Acute care admissions
  - b. Rehabilitation admissions
2. Skilled nursing facilities; and
3. Residential behavioral health treatment facilities if you selected the chemical dependency option on your Contract Schedule and Application.

To provide preadmission notification, call the customer service number provided in the “Customer Service” section. They will direct your call.

## ***Emergency Admission Notification***

Notice is required as soon as reasonably possible for admission for a medical emergency or injury that occurred within 48 hours before admission.

If you have an emergency admission to a Nonparticipating Provider, you or the provider must notify us as soon as reasonably possible.

We pay only for services we determine are medically necessary. There is no penalty for failure to notify us of an emergency admission if we determine that the admission was medically necessary.

**To provide emergency admission notification, call the customer service number provided in the “Customer Service” section. They will direct your call.**

## BENEFIT CHART

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

### ***Benefit Features, Limitations, and Maximums***

<b>Benefit Features</b>	<b>Your Liability</b>
<b>Deductible</b> <ul style="list-style-type: none"><li>All providers combined</li></ul>	The amount per contract term for each person and family shown on the Contract Schedule and Application.
<b>Benefit Features</b>	<b>Limitations and Maximums</b>
<b>Out-of-Pocket Maximum</b> <ul style="list-style-type: none"><li>All providers combined</li></ul>	The amount per contract term for each person and family shown on the Contract Schedule and Application.
<b>Lifetime Maximum</b> <ul style="list-style-type: none"><li>All providers combined</li></ul>	\$1 million per person
<b>Dependents</b> <ul style="list-style-type: none"><li>Dependent child age limit</li><li>Student dependent age limit</li></ul>	19 years 25 years

### ***Benefit Descriptions***

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

## Ambulance

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"><li>• Ground transportation licensed to provide basic or advanced life support to the nearest medical facility equipped to treat the condition</li><li>• Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse</li></ul>	80% after you pay the deductible.	80% after you pay the deductible.
<b>NOTE:</b> <ul style="list-style-type: none"><li>• If we determine air ambulance was not medically necessary but ground ambulance would have been, this contract pays up to the allowed amount for medically necessary ground ambulance.</li></ul>		
<b>NOT COVERED:</b> <ul style="list-style-type: none"><li>• transportation services that are not medically necessary for basic or advanced life support</li><li>• transportation services that are mainly for your convenience</li><li>• please refer to the "General Exclusions" section</li></ul>		

THIS PAGE APPLIES ONLY IF YOU REQUESTED THE CHEMICAL DEPENDENCY OPTION ON YOUR CONTRACT SCHEDULE AND APPLICATION

**Chemical Dependency**

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Outpatient health care professional charges</li> <li>• Outpatient hospital/outpatient behavioral health treatment facility charges</li> <li>• Inpatient health care professional charges</li> <li>• Inpatient hospital/residential behavioral health treatment facility charges</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**NOTES:**

- **Please see the “Notification Requirements” section.**
- Call 1-800-469-1110 prior to obtaining treatment and the behavioral health staff will direct you to the appropriate Behavioral Health Network Provider. If a Behavioral Health Network Provider is not available within a medically appropriate time for treatment and service, the behavioral health staff will recommend an alternative provider.
- 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. An initial court-ordered exam for a dependent child under the age of 18 is also considered medically necessary without further review by us.
- 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 contract.
- Outpatient family therapy is covered if part of a recommended treatment plan.
- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire admission.
- For lab and x-ray services billed by a health care professional, please refer to “Physician Services.” For lab and x-ray services billed by a facility, please refer to “Hospital Inpatient” and “Hospital Outpatient.”
- For chemical dependency services or treatment, the allowed amount for Nonparticipating Providers is either at the amount agreed to between us and the provider, or if no such agreement, the lesser of the provider’s billed charges or the prevailing payment amount for the treatment or services in the area where services are performed.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

**NOT COVERED:**

- services to hold or confine a person under chemical influence when no medical services are required
- custodial and supportive care
- court-ordered services that are not medically necessary
- please refer to the “General Exclusions” section

## Chiropractic Care

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• Spinal manipulations, manual muscle stimulations, or other conjunctive or manipulative therapies are limited to a maximum of 15 services per person per contract duration when you use a Nonparticipating Provider.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• services primarily educational in nature</li> <li>• vocational rehabilitation</li> <li>• self-care and self-help training (nonmedical)</li> <li>• health clubs and spas</li> <li>• recreational therapy</li> <li>• rehabilitation services that would not result in measurable progress relative to established goals</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Dental Care

This Contract Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Accident-related dental services from a physician or dentist for the treatment of an injury to sound, natural teeth</li> <li>• Treatment of cleft lip and palate for a dependent child</li> <li>• Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.

### NOTES:

- **Please see the “Notification Requirements” section.**
- The above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this contract.
- Treatment of cleft lip and palate includes inpatient and outpatient expenses arising from medical and dental treatment, including orthodontia and oral surgery. For medical services please refer to “Hospital Inpatient,” “Hospital Outpatient,” “Physician Services,” etc.
- Treatment for cleft lip and palate is limited to services that are scheduled or initiated prior to the dependent child turning age 19.
- Services for surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.
- Orthognathic surgery is covered for the treatment of temporamandibular joint disorder (TMJ) and craniomandibular disorder.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or dental prosthesis.
- A sound, natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one (1) year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one (1) year. A dental implant is not a sound, natural tooth.
- Dependent child is defined by the age limit for a dependent child or student dependent, whichever is later, if applicable, as specified in this contract.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

### NOT COVERED:

- dental services to treat an injury from biting or chewing
- dentures and dental implants, regardless of the cause of the condition, and any associated services and/or charges
- removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except when related to the treatment of cleft lip and palate
- replacement of a damaged bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants
- all orthodontia, except when related to the treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder and for the treatment of cleft lip and palate up to the dependent child age limit

## Dental Care (continued)

### **NOT COVERED** (continued):

- tooth extractions, unless otherwise specified as covered
- any other dental procedure or treatment
- please refer to the “General Exclusions” section

## Emergency Care

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Outpatient health care professional charges</li> <li>• Outpatient hospital/facility charges</li> <li>• Inpatient health care professional charges</li> <li>• Inpatient hospital/facility charges</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• 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.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Home Health Care

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Skilled care ordered in writing by a physician and provided by Medicare-approved or other preapproved home health agency employees including but not limited to:               <ul style="list-style-type: none"> <li>▪ licensed registered nurse</li> <li>▪ licensed registered physical therapist</li> <li>▪ master's level clinical social worker</li> <li>▪ registered occupational therapist</li> <li>▪ certified speech and language pathologist</li> <li>▪ medical technologist</li> <li>▪ registered dietician</li> </ul> </li> <li>• Services of a home health aide or social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees</li> <li>• Use of appliances that are owned or rented by the home health agency</li> <li>• Medical supplies provided by the home health agency</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• Coverage is limited to a one (1) visit per day for the length of the contract duration selected on the Contract Schedule and Application.</li> <li>• Benefits for home infusion therapy and related home health care are listed under “Home Infusion Therapy.”</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• custodial or nonskilled care</li> <li>• services of a nonmedical nature</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Home Infusion Therapy

This Contract Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Home infusion therapy services when ordered by a physician</li> <li>• Solutions and pharmaceutical additives, pharmacy compounding and dispensing services</li> <li>• Durable medical equipment</li> <li>• Ancillary medical supplies</li> <li>• Nursing services to:               <ul style="list-style-type: none"> <li>▪ train you or your caregiver</li> <li>▪ monitor the home infusion therapy</li> </ul> </li> <li>• Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy</li> <li>• Other eligible home health services and supplies provided during the course of home infusion therapy</li> </ul>	<p>80% after you pay the deductible.</p>	<p>When you use a Nonparticipating Provider, there is <b>NO COVERAGE</b> unless an exception is noted below.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• There is no coverage for services you receive from a Nonparticipating Provider unless the provider is located outside the state of Minnesota and is a member of the participating network of their local Blue Cross and/or Blue Shield.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• home infusion services or supplies not specifically listed as covered services</li> <li>• nursing services to administer therapy that you or another caregiver can be successfully trained to administer</li> <li>• services that do not involve direct patient contact, such as delivery charges and recordkeeping</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Hospital Inpatient

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Semiprivate room and board and general nursing care (private room is covered only when medically necessary)</li> <li>• Intensive care and other special care units</li> <li>• Operating, recovery, and treatment rooms</li> <li>• Anesthesia</li> <li>• Prescription drugs and supplies used during a covered hospital stay</li> <li>• Lab and x-ray</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• This contract covers kidney and cornea transplants. For other kinds of transplants, refer to “Organ and Bone Marrow Transplant Coverage.”</li> <li>• This contract 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 this contract; <ul style="list-style-type: none"> <li>▪ potential donor testing;</li> <li>▪ donor evaluation and work-up; and</li> <li>▪ hospital and professional services related to organ procurement.</li> </ul> </li> <li>• This contract covers anesthesia and inpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• travel expenses for a kidney donor</li> <li>• kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this contract</li> <li>• kidney donor expenses when the recipient is not covered for the kidney transplant under this contract</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Hospital Outpatient

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Scheduled surgery/anesthesia</li> <li>• Radiation and chemotherapy</li> <li>• Kidney dialysis</li> <li>• Respiratory therapy</li> <li>• Physical, occupational, and speech therapy</li> <li>• Lab and x-ray</li> <li>• Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>• All other eligible outpatient hospital care</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• This contract covers anesthesia and outpatient hospital charges for dental care provided to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Medical Equipment, Prosthetics and Supplies

This Contract Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds</li> <li>• Medical supplies including splints, surgical stockings, casts, and dressings</li> <li>• Insulin pumps, glucometers and related equipment and devices</li> <li>• Blood, blood plasma, and blood clotting factors</li> <li>• Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes</li> <li>• Special dietary treatment for phenylketonuria (PKU) when recommended by a physician</li> <li>• Corrective lenses for aphakia</li> <li>• Scalp hair prosthesis (wigs) provided hair loss is due to alopecia areata. Maximum of \$350 per person per calendar year. Deductible does not apply.</li> <li>• Custom foot orthotics if you have a diagnosis of diabetes with neurological manifestations and you have arthropathy and/or ulcer(s) of the lower limbs</li> <li>• Hearing aids for children age 18 and younger who have a hearing loss due to a congenital malformation that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years.</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>

**NOTES:**

- **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. The exception to this requirement is oxygen-aiding equipment which requires continuous maintenance.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- For coverage of insulin and diabetic supplies, refer to “Prescription Drugs and Insulin.”
- Rental of an electric breast pump is eligible for coverage only when there is maternal-infant separation due to illness, prematurity, or hospitalization and only for the duration of the separation.
- You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.

## Medical Equipment, Prosthetics, and Supplies (continued)

### NOT COVERED:

- rental or purchase of a manual breast pump and/or the purchase of an electric breast pump
- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding
- 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 purposes or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hot tubs, whirlpools, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, and incontinence pads or pants
- modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's condition would deteriorate
- eyeglasses, contact lenses, or other optical devices or professional services to fit or supply them, except as provided in the "Benefit Chart"
- duplicate equipment, prosthetics, or supplies
- services for or related to arch supports, orthopedic shoes and foot orthotics, including, but not limited to, such related services as biomechanical evaluation, range of motion measurements and report, and negative foot mold impressions except as provided in the "Benefit Chart"
- contraceptive devices
- hearing aids or devices, whether internal, external, or implantable, and related fitting or adjustment except for hearing aids for children age 18 and younger who have a hearing loss due to a congenital malformation that cannot be corrected by other covered procedures
- please refer to the "General Exclusions" section

## Organ and Bone Marrow Transplant Coverage

This Contract Covers:	Blue Quality Centers for Transplant (BQCT) Providers	Non-Blue Quality Centers for Transplant (BQCT) Providers
<p>The following medically necessary human organ and bone marrow transplant and peripheral stem cell support procedures:</p> <ul style="list-style-type: none"> <li>• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell support procedures</li> <li>• Autologous bone marrow transplant and peripheral stem cell support procedures</li> <li>• Heart, heart-lung, liver (cadaver and living), lung (single or double)</li> <li>• Small-bowel or small-bowel/liver</li> <li>• Pancreas transplant               <ul style="list-style-type: none"> <li>▪ Cadaver – eligible as pancreas transplantation alone (PTA), simultaneous pancreas and kidney transplantation (SPK), or pancreas transplantation after kidney transplantation (PAK), or</li> <li>▪ Living donor segmental pancreas transplantation – eligible alone, at the time of, or following kidney transplantation</li> </ul> </li> </ul>	<p>100% of the Transplant Payment Allowance for the transplant admission.</p> <p>If you live more than 50 miles from a BQCT Provider, there may be benefits available for travel, meals and lodging expenses directly related to a preauthorized transplant. For more information contact the Transplant Coordinator at the number listed below.</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> 80% of the Transplant Payment Allowance after you pay the deductible for the transplant admission.</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> <b>NO COVERAGE.</b></p>

**NOTES:**

- **As technology changes, the covered transplants listed above will be subject to modifications in the form of additions or deletions, when appropriate.**
- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for organ and bone marrow transplants listed above. See “Hospital Inpatient” and “Physician Services.”
- **Prior authorization is required for all transplant and peripheral stem cell support procedures. All requests for prior authorization must be submitted in writing to:**

Blue Cross and Blue Shield of Minnesota  
Transplant Coordinator  
P.O. Box 64179  
St. Paul, Minnesota 55164

**If you have specific questions on Organ and Bone Marrow Transplant Coverage, call the Transplant Coordinator of Blue Cross and Blue Shield of Minnesota, Monday through Friday, from 8:00 a.m. to 4:30 p.m. (Central Time) at (651) 662-1624 or 1-888-878-0139, extension 21624.**

## Organ and Bone Marrow Transplant Coverage (continued)

### NOT COVERED:

- benefits for travel, meals and lodging expenses when you are using a Non-BQCT 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 contract
- transplantation of animal organs and/or tissue
- additional exclusions are listed in the "General Exclusions" section

### DEFINITIONS:

- *BQCT Provider* means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association to provide organ or bone marrow transplant or peripheral stem cell support 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 organ or bone marrow transplant or peripheral stem cell support procedures.
- *Transplant Payment Allowance* means the amount the contract pays for covered services to a BQCT Provider or a Participating Transplant Provider for services related to organ or bone marrow transplant or peripheral stem cell support procedures in the agreement with that provider.

## Physical, Occupational, and Speech Therapy

This Contract Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech therapy</li> </ul>	80% after you pay the deductible.	80% after you pay the deductible.
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• Physical, speech, and occupational therapy are limited to a <i>combined</i> maximum of 15 services per person per contract duration when you use a Nonparticipating Provider.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• services primarily educational in nature</li> <li>• vocational rehabilitation</li> <li>• developmental delay services</li> <li>• self-care and self-help training (nonmedical)</li> <li>• health clubs and spas</li> <li>• learning disabilities and disorders</li> <li>• recreational therapy</li> <li>• rehabilitation services that would not result in measurable progress relative to established goals</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Physician Services

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Office visits for illness</li> <li>• Routine cancer screening (including, but not limited to mammograms, Pap smears, flexible sigmoidoscopies, colonoscopies, occult blood work, prostate specific antigen (PSA) tests, and surveillance tests for ovarian cancer)</li> <li>• Allergy testing, serum, and injections</li> <li>• Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>• Lab and x-ray</li> <li>• Inpatient hospital/facility visits during a covered admission</li> <li>• Outpatient hospital/facility visits</li> <li>• Anesthesia by a provider other than the operating, delivering, or assisting provider</li> <li>• Surgery</li> <li>• Assistant surgeon</li> <li>• Bariatric surgery to correct morbid obesity</li> <li>• Kidney and cornea transplants</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• If more than one (1) surgical procedure is performed during the same operative session, this contract covers the surgical procedures based on the allowed amount for each procedure. This contract does not cover a charge separate from the surgery for pre- and post-operative care.</li> <li>• This contract covers treatment of diagnosed Lyme disease on the same basis as any other illness.</li> <li>• You are entitled to receive care at the In-Network level for the following services from providers who are not affiliated with us: <ul style="list-style-type: none"> <li>▪ the voluntary planning of the conception and bearing of children;</li> <li>▪ the diagnosis of infertility;</li> <li>▪ the testing and treatment of a sexually transmitted disease; or</li> <li>▪ the testing of AIDS or other HIV-related conditions.</li> </ul> </li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• repair of scars and blemishes on skin surfaces</li> <li>• separate charges for pre- and post-operative care for surgery</li> <li>• cosmetic surgery to repair a physical defect, except as described on the “Reconstructive Surgery” page</li> <li>• kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this contract</li> <li>• kidney donor expenses when the recipient is not covered under this contract</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Prescription Drugs and Insulin

This Contract Covers:	Participating Pharmacy	Nonparticipating Pharmacy
<ul style="list-style-type: none"> <li>• Prescription drugs, insulin and drug therapy supplies</li> <li>• Prescription injectable drugs that are self-administered or administered by a health care professional</li> <li>• Smoking cessation drugs</li> </ul>	<p>When you present your ID card or otherwise provide notice of coverage at the time of purchase, you pay 20% after you pay the deductible. Once you have reached the Out-of-Pocket Maximum, your prescription is covered in full to the end of the contract duration.</p> <p>If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, you will be charged the full amount of the prescription drug. You will be reimbursed only the discounted pricing that has been negotiated between us and the Participating Pharmacy for that prescription drug less your prescription drug coinsurance and deductible. Your out-of-pocket costs may be significantly higher when you do not provide proof of insurance at the time of purchase.</p>	<p>You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. You will be reimbursed only the discounted pricing that has been negotiated between us and a Participating Pharmacy for that prescription drug less your prescription drug coinsurance and deductible.</p>

**NOTES:**

- **Please see the “Notification Requirements” section.**
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. The information on your ID card enables the Participating Pharmacy to connect electronically with us to access discounted pricing information. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any coinsurance and deductibles, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing we have negotiated with participating pharmacies for that prescription drug.
- Prescription drugs and diabetic supplies are covered in a 31-day supply. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- The following diabetic supplies are covered at the same level as prescription drugs when prescribed by a physician: blood/urine testing tabs/strips, needles and syringes, lancets, and insulin.

## Prescription Drugs and Insulin (continued)

### NOTES (continued):

- This contract will cover prescription smoking cessation products and over-the-counter nicotine replacement products (limited to nicotine patches and gum) with a physician's prescription. Some quantity limitations may apply.
- This contract will cover off label drugs used for cancer treatment as specified by law.
- When identical chemical entities are manufactured by separate companies, the Blue Cross Pharmacy and Therapeutics (P&T) Committee may determine that only one of those drug products is covered and the other equivalent products are not covered. The P&T Committee is comprised of actively practicing physicians and pharmacists. The purpose of the Committee is to decide which medications are added and removed from the Blue Cross Formulary. The Committee makes determinations on the basis of each medication's safety, efficacy, uniqueness, and cost.
- To locate a Participating Pharmacy in your area, call the pharmacy information number provided in the "Customer Service" section.
- For drugs dispensed and used during an admission, see "Hospital Inpatient."
- For supplies or appliances, except as provided in this "Benefit Chart," see "Medical Equipment, Prosthetics, and Supplies."
- A compound drug is a prescription where two (2) or more medications are mixed together. One (1) of these drugs must be a Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added.
- When you pay for your prescription drugs, insulin, and drug therapy supplies yourself, you are required to submit the drug receipt(s) with a claim form for reimbursement.
- We may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under this contract. Such discounts are the sole property of Blue Cross and will not be considered in calculating any coinsurance, copay, or benefit maximums.

### NOT COVERED:

- charges for giving injections that can be self-administered
- over-the-counter drugs unless otherwise specified
- investigative or non-FDA approved drugs
- vitamin or dietary supplements
- contraceptives (including insertion and removal)
- smoking cessation drugs without a prescription
- prescription drugs for or related to infertility treatments, assisted reproductive technology (ART), artificial insemination or in vitro fertilization
- nonprescription supplies such as alcohol, cotton balls, and alcohol swabs
- selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
- please refer to the "General Exclusions" section

## Reconstructive Surgery

This Contract Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part</li> <li>• Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician</li> <li>• Treatment of cleft lip and palate for a dependent child</li> <li>• Elimination or maximum feasible treatment of port wine stains</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• <b>Please see the “Notification Requirements” section.</b></li> <li>• 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 has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.</li> <li>• Dependent child is defined by the age for dependent child or student dependent, whichever is later, if applicable, as specified in this contract.</li> <li>• Congenital means present at birth.</li> <li>• Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or dental prosthesis.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• repair of scars and blemishes on skin surfaces</li> <li>• dentures and dental implants, regardless of the cause or condition, and any associated services and/or charges</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

## Skilled Nursing Facilities

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"> <li>• Skilled care ordered by a physician and eligible under Medicare guidelines</li> <li>• Semiprivate room and board</li> <li>• General nursing care</li> <li>• Prescription drugs used during admission</li> <li>• Physical, occupational and speech therapy</li> </ul>	<p>80% after you pay the deductible.</p>	<p>80% after you pay the deductible.</p>
<p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• If you are unable to obtain a bed in an In-Network skilled nursing facility within a 50-mile radius of your home, due to full capacity, you may be eligible to receive services at an Out-of-Network skilled nursing facility at the In-Network level of coverage.</li> <li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li> </ul>		
<p><b>NOT COVERED:</b></p> <ul style="list-style-type: none"> <li>• custodial or nonskilled care</li> <li>• services of a nonmedical nature</li> <li>• please refer to the “General Exclusions” section</li> </ul>		

### Well-Child Care

<b>This Contract Covers:</b>	<b>In-Network Providers</b>	<b>Out-of-Network Providers</b>
<ul style="list-style-type: none"><li>• The following services for a dependent child from birth to age six (6):<ul style="list-style-type: none"><li>▪ preventive services</li><li>▪ developmental assessments</li><li>▪ laboratory services</li></ul></li><li>• Immunizations for a dependent child from birth to age 18</li></ul>	100%	100%
<b>NOTE:</b> <ul style="list-style-type: none"><li>• You pay all charges that exceed the allowed amount when you use a Nonparticipating Provider.</li></ul>		
<b>NOT COVERED:</b> <ul style="list-style-type: none"><li>• please refer to the "General Exclusions" section</li></ul>		

## **BENEFIT SUBSTITUTION**

Benefit substitution, a process of substituting one (1) covered benefit for another covered benefit, is used by our care/case managers to facilitate care/case management plans for patients with complex health care needs. The benefit substitution process will be used only when:

1. a care/case management plan is developed in collaboration with the patient and the health care provider prior to the services being provided; and
2. a physician writes an order stating the services to be provided are medically necessary; and
3. the services being provided under the care/case management plan meet the skilled care requirements of the benefit to be used; and
4. the services do not exceed the allowed amount of the benefit being used.

The benefit substitution process cannot be applied retrospectively, and benefit substitution cannot be used to allow coverage for services or supplies excluded by the contract.

The decision to use the benefit substitution process is at our sole discretion. Our decision to use the benefit substitution process in a particular case in no way commits us to do so at another point in the same case or in another case, nor does it prevent us from strictly applying the express benefits, limitations and exclusions of the contract at any other time or for any other insured person.

## GENERAL EXCLUSIONS

We do not pay charges for:

1. Services for conditions that are determined to be preexisting conditions in accordance with the terms of this contract. A preexisting condition is any injury, illness or condition for which you or your eligible dependent have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract. A pregnancy existing any time prior to the effective date of your coverage is considered a preexisting condition.
2. Services or supplies for the diagnosis or treatment of alcoholism, chemical dependency or drug addiction unless you selected the chemical dependency option on your Contract Schedule and Application.
3. Services for or related to the treatment or diagnosis of any mental or nervous disorder.
4. Services for or related to marriage counseling or training.
5. Treatments, services or supplies which are not medically necessary.
6. Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by us in advance of treatment.
7. Charges for or related to care that is custodial or not normally provided as preventive care or treatment of an illness.
8. Services that are normally provided without charge, including services of the clergy.
9. Services a provider gives to himself/herself or to a close relative such as spouse, brother, sister, parent, grandparent and/or child.
10. Services and supplies due to pregnancy, childbirth, early termination of pregnancy, or any complication of pregnancy.
11. Services performed before the effective date of your coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.
12. The portion of eligible services and supplies paid or payable under Medicare.
13. Services for dependents if you have single coverage only. If the subscriber to whom the contract is issued requests dependent coverage, please refer to the "Eligibility" section on how to add dependents.
14. 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.
15. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.
16. Blood pressure monitoring devices.

17. Nonprescription (over-the-counter) drugs or medicines, except as specified in the "Benefit Chart;" vitamin therapy or treatment; appetite suppressants; prescription drugs classified as not effective by the FDA; bioengineered drug therapy that has not received FDA approval for the specific use being requested, except for off-label drugs used for cancer treatment as specified by law; and prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
18. Personal comfort items, such as telephone, television, barber and beauty supplies, guest services, etc.
19. Autopsies.
20. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the "Benefit Chart."
21. Charges made by a health care professional for telephone consultations.
22. Charges for furnishing medical records or reports.
23. Charges for failure to keep scheduled visits.
24. 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 injuries.
25. This contract does not pay for services that are provided to you for the treatment of an employment related injury for which you are entitled to make a worker's compensation claim unless the worker's compensation carrier has disputed the claim.
26. Charges that are eligible, paid or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, copay or coinsurance requirement of such a policy.
27. Services needed because you engaged in an illegal occupation or committed or attempted to commit a felony.
28. Services that are prohibited by law or regulation.
29. Admission for diagnostic tests that can be performed on an outpatient basis.
30. Services or confinements ordered by a court or law enforcement officer that are not medically necessary. Services that are not medically necessary include, but are not limited to, the following: custody evaluations, parenting assessment, education classes for DUI offenses, competency evaluations, adoption home status, parental competency, and domestic violence programs.
31. Inpatient hospital room and board expense that exceeds the semiprivate room rate, unless a private room is approved by us as medically necessary.
32. 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."
33. Services for or related to private-duty nursing.

34. 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.
35. Charges for giving injections which can be self-administered.
36. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
37. 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.
38. Charges for rehabilitation services that would not result in measurable progress relative to established goals.
39. Services for or related to recreational or educational therapy, 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, massage therapy, etc., and all related material and products for these programs.
40. Services for or related to sex transformation/gender reassignment, sex hormones related to surgery, related preparation and follow-up treatment, or care and counseling, unless medically necessary as determined by us prior to receipt of the services.
41. Services and prescription drugs for or related to assisted reproductive technology (ART), artificial insemination or in vitro fertilization.
42. Services for or related to sterilization (except when due to disease of the reproductive organs), or the reversal of sterilization.
43. Preventive care, local tests, public health tests, routine screening tests, physical exams, immunizations and vaccinations except charges for well-child care, routine cancer screening, or similar benefits specified as eligible in this contract.
44. Services for or related to hearing aids or devices, whether internal, external, or implantable and related fitting or adjustment, except as specified in the "Benefit Chart."
45. 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."
46. Dentures and dental implants, regardless of the cause or condition, and any associated services and/or charges including bone grafts.
47. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the "Benefit Chart."
48. 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."

49. Services for or related to therapeutic acupuncture except for the treatment of chronic pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery and chemotherapy.
50. 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.
51. 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 chelation therapy that are not medically necessary. Services for or related to homeopathy.
52. Any services for or related to fetal tissue transplantation.
53. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
54. 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.
55. Services for or related to smoking cessation program fees and/or related program supplies.
56. Services which are not within the scope of licensure or certification of a provider.
57. Coverage for communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
58. Services for or related to hospice care.

***Eligible Dependents***

1. Legally married opposite gender spouse.
2. Unmarried natural-born dependent children to the dependent child age limit shown on the “Benefit Chart.”
3. Unmarried legally adopted children and children placed with you for adoption to the dependent child age limit shown on the “Benefit Chart.” Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligation of total or partial support.
4. Unmarried grandchildren to the dependent child age limit shown on the “Benefit Chart” who live with you continuously from birth and are financially dependent upon you.
5. Unmarried children of the contractholder who are required to be covered by reason of a Qualified Medical Child Support Order.
6. Unmarried dependent children to the full-time student age limit shown on the “Benefit Chart” if the following apply:
  - a. your dependent child must attend a college, university or trade school with a defined course of study; and
  - b. your dependent child must attend on a full-time basis as defined by the educational institution; or
  - c. if your dependent is unable to carry 100% of the full-time course load due to illness, injury or physical or mental disability documented by a physician, your dependent will remain eligible if he/she carries at least 60% of the full-time course load.

If your dependent child has not graduated or completed a defined course of study, your student dependent may miss one (1) academic term, as defined below, during an academic year and remain eligible as a student dependent. However, if your student dependent does not return to school on a full-time basis immediately following the missed academic term, coverage will be terminated at the end of the last month of the missed academic term. We reserve the right to require a paid fee statement indicating the term and number of credits for verification purposes. For the purposes of this section, “academic term” is defined as follows:

- Fall academic term – September 1 through December 31;
- Spring academic term – January 1 through May 31;
- Summer academic term – June 1 through August 31.

Coverage will terminate at the end of the month in which the student dependent graduates or completes a defined course of study.

7. Unmarried handicapped dependent children who reach the dependent child age limit shown on the “Benefit Chart” while covered under this contract if all of the following apply:
  - a. primarily dependent upon you; and
  - b. are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders; and

- c. for whom application for extended coverage as a handicapped dependent child is made within 31 days after reaching the age limit. After this initial proof, we may request proof again two (2) years later, and each year thereafter; and
- d. must have become handicapped prior to reaching the limiting age.

### ***Effective Date of Coverage***

This contract is issued subject to the statements made on your application and your payment in advance of the required charges.

If you mail your application, give your application to an agent, or deliver it to an outside office, the effective date is the day we receive the application in our home office, or the requested effective date, whichever is later. If you bring the application to our home office, your coverage will be effective the following day or the requested effective date, whichever is later.

This contract is issued for the number of days indicated on the Contract Schedule and Application attached to this contract. The coverage starts and ends at 12:00 a.m. at the place you live. Charges are not refundable except as provided on the cover page of this contract.

### ***Adding Newborns and Children Placed for Adoption***

Your newborn child or newborn grandchild is covered without health history requirements starting on the date of birth. In order to avoid claim delays, we request that you submit payment of all required charges and written application within 30 days after birth. If you submit an application more than 30 days after birth, your newborn child or newborn grandchild will still be added retroactive to the date of birth and you will be responsible for any premium due from the date of birth.

Your adopted child is covered without health history requirements starting on the date of placement with you for adoption. In order to avoid claim delays, we request that you submit payment of all required charges and written application within 30 days after placement. If you submit an application more than 30 days after placement, your adopted child will still be added retroactive to the date of placement and you will be responsible for any premium due from the date of placement. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.

### ***Renewal of This Contract***

This contract is issued for a specific term of days, as indicated on the Contract Schedule and Application attached to this contract. This contract cannot be renewed. You may apply for a new contract for an additional contract duration. If you apply for and are issued a new contract, any condition treated under this contract will be considered a preexisting condition which is not covered under the new contract.

### ***Termination of Coverage***

This contract terminates at the end of the contract duration selected on the Contract Schedule and Application, except in instances where you or your covered dependent are confined to a hospital on that date. For that person, we will extend the contract duration only for the condition causing the hospital confinement. The extension will end when the person is no longer confined to the hospital or when the lifetime maximum has been paid, whichever occurs first.

Coverage for dependents ends when the contract duration ends or when the dependent is no longer eligible, whichever occurs first.

## ***Coordination of Benefits***

This section applies when you obtain group health care coverage while you are covered under this contract. Group coverage is primary and determines benefits first. Your benefits under this contract are reduced so that the total benefits do not exceed 100% of covered expenses.

Certain facts are needed to coordinate benefits. We have the right to decide which facts are needed. We may get needed facts from, or give them to, any other organization or person. We do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this contract must give us any facts needed to pay the claim.

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

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

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

## REIMBURSEMENT AND SUBROGATION

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

Our right to reimbursement and subrogation is subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless we are separately represented by our own attorney. If we are separately represented by an attorney, we may enter into an agreement with you regarding your costs, disbursements and reasonable attorney fees and other expenses. If we cannot reach agreement on such allocation, the matter on allocation shall be submitted to binding arbitration.

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

### Notice Requirement

**You must provide timely written notice to us of the pending or potential claim,** if you make a claim against a third party for damages that include repayment for medical and medically related expenses incurred for your benefit. Notwithstanding any other law to the contrary, the statute of limitations applicable to our rights for reimbursement or subrogation does not commence to run until the notice has been given.

## 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 must file the claim yourself. Claim forms are available by calling the toll free Customer Service telephone number listed in the front of this contract. You can also write us at the address listed in the front of this contract. You must file a written claim within 90 days after a covered service is provided. If this is not reasonably possible, we accept claims for up to 15 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 within 90 days after we receive the claim and any other required information. Under special circumstances, the time period for making a decision may be extended to 180 days after we receive the claim and any other required information. If you do not receive a written explanation within 90 days (or 180 days if there has been an extension) you should consider the claim denied and you can request a review of the denial.

If your claim is denied in whole or in part, we will give you the specific reason for our decision in writing. If you do not agree with the decision and want the decision to be reviewed, you must file a written request for review (i.e., an appeal) with us within 60 days after receiving the notice of your claim denial. You or your representative can present written statements which explain why you believe the benefit claim should be paid and may review this contract.

Generally, the decision will be reviewed within 60 days after we receive a request for review. If, however, special circumstances require a delay, the review may take up to 120 days. If a decision cannot be made within the 60-day period, you will be notified in writing. After the decision has been reviewed, you will receive a written notice of the decision, which will explain the reason for the decision by making specific reference to the provisions of this contract on which the decision is based.

### ***Right of Examination***

We have the right to ask you to be examined by a provider during the review of any claim. We choose the provider and pay for the exam whenever we request this. Failure to comply with this request may result in denial of your claim.

### ***Release of Records***

You agree to allow all health care providers to give us needed information about the care they provide to you. We may need this information to process claims, conduct utilization review, care management, 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 a denial of your claim.

### ***Entire Contract***

The contractholder hereby expressly acknowledges his/her understanding that this contract, Contract Schedule and Application constitutes a contract solely between the contractholder and Blue Cross . Please refer to "Independent Corporation" in the front of this contract.

## ***Misstatements***

We issue this contract based on the statements you made on your application. If your application contained misstatements or falsifications that affected our approval of your application, we may rescind the coverage or deny payment of claims. If you misstate your age on your application, we reserve the right to rescind coverage or collect the balance due on the term charge for your correct age.

## ***Whom We Pay***

When you use an In-Network Provider for covered services, we pay the provider. When you use an Out-of-Network Provider for covered services, we pay you. You may not assign your benefits to an Out-of-Network Provider, except when parents are divorced. In that case, the custodial parent may ask us to pay an Out-of-Network Provider for covered services for a child. When we pay the provider at the request of the custodial parent, we have met our obligation under this contract. This provision may be waived for certain out-of-state institutional and medical/surgical providers.

## ***Payment of Charges***

All charges for your Insta-Care coverage must be prepaid.

## 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. You may file your complaint with the Commissioner of Commerce at any time by calling 1-800-657-3602 or 651-296-4026.

### ***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 contract.

*Complaint* means any grievance that is not the subject of litigation concerning any aspect of the provision of health services under your contract. 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 days. If our resolution of your oral complaint is wholly or partially adverse to you, we will provide you with 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 a written reconsideration, concise written notice of our decision and all key findings will be given to you within 30 days after we receive your written notice of appeal.

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

## ***External Review***

If your complaint concerns a covered health care service or claim and you believe Blue Cross' voluntary 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. 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 Commissioner of Commerce along with a filing fee. The commissioner may waive the fee in cases of financial hardship.

Minnesota Department of Commerce  
Attention: Enforcement Division  
85 7<sup>th</sup> Place East, Suite 500  
St. Paul, MN 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 any 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 contract.

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 contract.

*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 within 10 business days of the request provided that all information reasonably necessary to make a determination on your request has been made available to us. When we authorize services, we notify the provider by telephone and in writing. When we determine not to authorize the services, we notify the attending health care professional and hospital by telephone, and notify the attending health care professional, hospital, and enrollee in writing. When a determination is made not to authorize a service, notification by telephone will be made within one (1) working day. 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, in writing or by telephone, Blue Cross' decision to not authorize services. 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

These terms have special meaning in this contract.

<b>Term</b>	<b>Definition</b>
<b>Admission</b>	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
<b>Advanced Practice Nurses</b>	Licensed registered nurses who have gained additional knowledge and skills through and organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
<b>Allowed Amount</b>	<p>The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as noted in the "Benefit Chart."</p> <p>For In-Network Providers, the allowed amount is the negotiated amount of payment that the In-Network 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 In-Network Providers as a result of expected settlements or other factors. The negotiated amount of payment with In-Network 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 settlements, rebates, and other methods, we may subsequently adjust the amount due to an In-Network Provider. These subsequent adjustments will not impact or cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to us, and the percentage of the allowed amount paid by us is lower than the stated percentage for the covered service. If the payment to the provider is increased, we pay that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.</p> <p>For Nonparticipating Providers, the allowed amount is the lesser of billed charge or a percentage of what we would pay an In-Network Provider for the same or similar services.</p>
<b>Attending Health Care Professional</b>	A health care professional with primary responsibility for the care provided to a sick or injured person.
<b>Average Semiprivate Room Rate</b>	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.
<b>Behavioral Health Network Provider</b>	A health professional that participates in a special network for the provision of chemical dependency treatment services. This definition applies only if you selected the chemical dependency option on your Contract Schedule and Application.

<b>Term</b>	<b>Definition</b>
<b>Benefit Chart</b>	The schedule that lists benefits and covered services.
<b>BlueCard Program</b>	A national Blue Cross and Blue Shield program in which you can receive health plan benefits while traveling or living outside of your service area. You must use Participating Providers and show your membership ID to secure BlueCard Program benefits.
<b>Care/Case Management Plan</b>	A plan for health care services developed for a specific patient by one of our care/case managers after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.
<b>Chemical Dependency</b>	Alcohol or drug dependence as defined in the most current edition of the <i>International Classification of Diseases</i> . This definition applies only if you selected the chemical dependency option on your Contract Schedule and Application.
<b>Claims Administrator</b>	Blue Cross and Blue Shield of Minnesota (BCBSM) (Blue Cross).
<b>Coinsurance</b>	<p>The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket maximum. For covered services from In-Network Providers, coinsurance is calculated based on the lesser of the allowed amount or the In-Network Provider's billed charge. Because payment amounts are negotiated with In-Network Providers to achieve overall lower costs, the allowed amount for In-Network 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 In-Network Providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.</p> <p>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.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.</p> <p>Coinsurance Example:</p> <p>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:</p> <p>For instance, when we pay 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount.</p>

Term	Definition
	<p>In addition, you would be responsible for any excess charge over our allowed amount when a Nonparticipating Provider is used. For example, if a Nonparticipating Provider ordinarily charges \$100 for a service, but our allowed amount is \$95, we will pay 80% of the allowed amount (\$76). You must pay the 20% coinsurance on our allowed amount (\$19), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$24.</p> <p>Remember, if In-Network Providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on our allowed amount. If Nonparticipating Providers are used, your out-of-pocket costs will be higher as shown in the example above.</p>
<b>Compound Drug</b>	<p>A prescription where two (2) or more medications are mixed together. One (1) of these drugs must be Federal legend drug. The end product must not be available in an equivalent commercial form. A prescription will not be considered as a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added.</p>
<b>Comprehensive Pain Management Program</b>	<p>A multidisciplinary program including, at a minimum, the following components:</p> <ol style="list-style-type: none"> <li>1. a comprehensive physical and psychological evaluation;</li> <li>2. physical/occupational therapies;</li> <li>3. a multidisciplinary treatment plan; and</li> <li>4. a method to report clinical outcomes.</li> </ol>
<b>Cosmetic Services</b>	<p>Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.</p>
<b>Covered Services</b>	<p>A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.</p>
<b>Custodial Care</b>	<p>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, and helping you to walk, get in and out of bed, dress, eat, bathe, and use the toilet.</p>
<b>Deductible</b>	<p>The amount you must pay toward the allowed amount for certain covered services each year before we begin to pay benefits. The deductibles for each person and family are shown on the Contract Schedule and Application.</p> <p>Your coinsurance and deductible amount will be based on the negotiated payment amount BCBSM 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 BCBSM may receive from other parties.</p>

<b>Term</b>	<b>Definition</b>
<b>Dependent</b>	Your spouse, unmarried child to the age specified on the "Benefit Chart," grandchild who is dependent on you, unmarried child who is a full-time student to the age specified on the "Benefit Chart," any other person whom state or federal law requires to be treated as a dependent, any grandchild who resides with you from birth and thereafter, or a child for whom you or your spouse have been appointed legal guardian.
<b>Durable Medical Equipment</b>	Medical equipment that we determine is prescribed by a physician that meets each of the following: <ol style="list-style-type: none"> <li>1. able to withstand repeated use;</li> <li>2. used primarily for a medical purpose;</li> <li>3. generally not useful in the absence of illness or injury;</li> <li>4. determined to be reasonable and necessary; and</li> <li>5. represents the most cost-effective alternative.</li> </ol>
<b>Facility</b>	A hospital, home health agency, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that facility. Reference to residential behavioral health treatment facility or outpatient behavioral health treatment facility applies only to plans that include benefits for chemical dependency, alcoholism or drug addiction.
<b>Foot Orthotic</b>	A foot orthotic is a rigid or semi-rigid orthopedic appliance or apparatus worn to support, align and/or correct deformities of the lower extremity.
<b>Freestanding Ambulatory Center</b>	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 center is not part of a hospital, a clinic, a doctor's office, or other health care professional's office.
<b>Health Care Professional</b>	A health care professional, licensed for independent practice, certified or otherwise qualified under state law to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, advanced practice nurses, physician assistants, audiologists, physical, occupational and speech therapists, and licensed registered dietitians. Health care professional also includes supervised employees of: doctors of medicine, osteopathy, chiropractic, or dental surgery.
<b>Home Health Agency</b>	A Medicare-approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.
<b>Hospital</b>	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.
<b>Illness</b>	A sickness, injury, chemical dependency (only if you selected the chemical dependency option on your Contract Schedule and Application), or condition involving a physical disorder.
<b>In-Network Provider</b>	A provider that has entered into a service agreement with us. In-Network Providers are also known as Participating Providers.

Term	Definition
<b>Investigative</b>	<p>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.</p> <ol style="list-style-type: none"> <li>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;</li> <li>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);</li> <li>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.</li> </ol> <p>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.</p>
<b>Lifetime Maximum</b>	<p>The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent's lifetime under all health plans sponsored by BCBSM. 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.</p>
<b>Medical Emergency</b>	<p>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 patient in serious jeopardy.</p>
<b>Medically Necessary</b>	<p>Health care services appropriate, in terms of type, frequency, level, setting and duration, to the individual's diagnosis or condition, diagnostic testing and preventive services. Medically necessary care must:</p> <ol style="list-style-type: none"> <li>1. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the conditions, procedures or treatment at issue;</li> <li>2. help restore or maintain the individual's health;</li> <li>3. prevent deterioration of the individual's condition; and</li> <li>4. prevent reasonable likely onset of a health problem or detect an incipient problem.</li> </ol>

<b>Term</b>	<b>Definition</b>
<b>Medicare</b>	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 has two (2) parts, Part A and Part B. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical and other services. Both Parts A and B do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.
<b>Nonparticipating Provider</b>	Providers who have not entered into a service agreement with the local Blue Cross and/or Blue Shield Plan.
<b>Out-of-Network Provider</b>	A provider that is not considered In-Network for the service being provided. Out-of-Network Providers are also called Nonparticipating Providers.
<b>Out-of-Pocket Maximum</b>	<p>The most each person must pay each year toward the allowed amount for covered services. The following items are applied to the out-of-pocket maximum:</p> <ol style="list-style-type: none"> <li>1. deductibles;</li> <li>2. coinsurance; and</li> <li>3. penalties for not giving us preadmission notification.</li> </ol> <p>After a person reaches the out-of-pocket maximum, we pay 100% of the allowed amount for covered services for that person for the rest of the contract term. The "Contract Schedule and Application" lists the out-of-pocket maximum amounts.</p>
<b>Outpatient Behavioral Health Treatment Facility</b>	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for 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. This definition applies only if you selected the chemical dependency option on your Contract Schedule and Application.
<b>Outpatient Care</b>	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
<b>Participating Provider</b>	Providers who have entered into a service agreement with the local Blue Cross and/or Blue Shield Plan.
<b>Physician</b>	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.
<b>Preexisting Condition</b>	Any injury, illness or condition for which you or your eligible dependent have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract. A pregnancy existing any time prior to the effective date of your coverage is considered a preexisting condition. (This provision does not apply to a dependent newborn child or a child who is placed for adoption during the term of this contract.)

<b>Term</b>	<b>Definition</b>
<b>Prescription Drugs</b>	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
<b>Provider</b>	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 freestanding ambulatory centers, home infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.
<b>Residential Behavioral Health Treatment Facility</b>	A facility that provides inpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for alcoholism, chemical dependency or drug addiction. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program. This definition applies only if you selected the chemical dependency option on your Contract Schedule and Application.
<b>Services</b>	Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs.
<b>Skilled Care</b>	Services that are medically necessary and must be provided by licensed registered nurses or other eligible providers. A service performed by, or under the direct supervision of, a licensed registered nurse or other eligible provider is not considered skilled care if the service can be safely and effectively self-administered or performed by a layperson.
<b>Skilled Nursing Facility</b>	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.
<b>Smoking Cessation Drugs</b>	Prescription and over-the-counter nicotine replacement therapies (limited to the nicotine patch and nicotine gum) and Sustained Release Bupropion sold under the brand name Zyban or other trade name designating use for smoking cessation.
<b>Supervised Employees</b>	Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery. The employing M.D., D.O., D.C., or D.D.S. 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.
<b>Supply</b>	<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"> <li>1. alcohol swabs;</li> <li>2. cotton balls;</li> <li>3. incontinence liners/pads;</li> <li>4. Q-tips;</li> <li>5. adhesives; and</li> <li>6. informational materials.</li> </ol>

<b>Term</b>	<b>Definition</b>
<b>Treatment</b>	The management and care of a patient for the purpose of combating an illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.
<b>Year</b>	January 1 <sup>st</sup> through December 31 <sup>st</sup> of each year.

