# NDHA Health Benefits Trust

## Summary Plan Description

## CompChoice 80 500

Health Care Coverage

This is a grandfathered Benefit Plan under the Patient Protection and Affordable Care Act (PPACA).

This health plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator and does not assume any financial risk except for stop-loss coverage.

This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.

01/01/2024 29382225

# MEMBER SERVICES

**Questions?**

Our Member Services staff is available to answer questions about your coverage –

**Call Member Services:**

Monday through Friday
7:30 a.m. - 5:00 p.m. CST

1-844-363-8457

**Office Address and Hours:**

You may visit our Home Office during normal business hours –

Monday through Friday
8:00 a.m. - 4:30 p.m. CST

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

**Mailing Address:**

You may write to us at the following address –

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

**Internet Address:**

www.BCBSND.com

**Offices:**

We invite you to contact the Office closest to you –

**Fargo Office**
4510 13th Avenue South
(701) 277-2232

**Jamestown Office**
300 2nd Avenue Northeast
Suite 132
(701) 251-3180

**Bismarck Office**
1415 Mapleton Avenue
(701) 223-6348

**Dickinson Office**
1674 15th Street West, Suite D
(701) 225-8092

**Grand Forks Office**
3570 South 42nd Street, Suite B
(701) 795-5340

**Devils Lake Office**
425 College Drive South, Suite 13
(701) 662-8613

**Minot Office**
1308 20th Avenue Southwest
(701) 858-5000

**Williston Office**
1500 14th Street West, Suite 270
(701) 572-4535

**Provider Directories:**

Members can obtain a Provider Directory or a list of Participating Pharmacies by calling the telephone number listed above or by visiting the BCBSND website.

Your employer has established a self-funded employee welfare benefit plan for eligible employees and their Eligible Dependents. The following Summary Plan Description is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information. This Summary Plan Description and the Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Summary Plan Description and the Service Agreement, the provisions of the Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the self-funded employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

The Claims Administrator shall have full, final and complete discretion to construe and interpret the provisions of the Service Agreement, the Summary Plan Description and related documents, including doubtful or disputed terms and to determine all questions of eligibility; and to conduct any and all reviews of claims denied in whole or in part. The decision of the Claims Administrator shall be final, conclusive and binding upon all parties.

**PLAN NAME**

NDHA Health Benefits Trust

**NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)**

North Dakota Hospital Association
1622 Interstate Avenue #B
Bismarck, ND 58503

**PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER**

87-1254624

**PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR**

501

**TYPE OF WELFARE PLAN**

Health

**TYPE OF ADMINISTRATION**

This is a self-funded employee welfare benefit plan with an individual stop-loss of $100,000 and an aggregate stop-loss of 120%. This plan is funded by NDHA Health Benefits Trust. The Claims Administrator does not underwrite, insure or assume liability for payment of Covered Services available under the Benefit Plan up to the stop-loss points. The Claims Administrator does not assume any obligation to pay claims except from funds contributed up to the stop-loss points.

**NAME AND ADDRESS OF CLAIMS ADMINISTRATOR**

Blue Cross Blue Shield of North Dakota (BCBSND)
4510 13th Avenue South
Fargo, North Dakota 58121

**PLAN ADMINISTRATOR'S NAME, BUSINESS ADDRESS AND BUSINESS TELEPHONE NUMBER**

NDHA Health Benefits Trust
1622 Interstate Avenue #B
Bismarck, ND 58503
701-224-9732

**NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS**

Plan Administrator:

Tim Blasl, Chair
NDHA Health Benefits Trust Board of Trustees
1622 Interstate Avenue #B
Bismarck, ND 58503

Claims Administrator:

Don Campbell
Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, North Dakota 58121

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

**NAME, TITLE AND ADDRESS OF THE PRINCIPAL PLACE OF BUSINESS OF EACH TRUSTEE OF THE PLAN**

Chelsey Tetrault, Trustee
Pembina County Memorial Hospital
301 Mountain Southeast
Cavalier, ND 58220

Erik Christenson, Vice Chair
Heart of America Medical Center
800 South Main
Rugby, ND 58368

Rachel Ray, Trustee
Unity Medical Center
164 West 13th Street
Grafton, ND 58237

Derek Schaff, Secretary/Treasurer
Linton Hospital
518 North Broadway
Linton, ND 58552

Tim Blasl, Chair
NDHA
1622 East Interstate Avenue
Bismarck, ND 58503

## TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Benefit Trust Administration/Communication Specialist
CFO, North Dakota Hospital Association
Vice President, North Dakota Hospital Association
Chair, NDHA Health Benefits Trust Board of Trustees
Consultants, Marsh McLennan Agency

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Member whose privacy may have been compromised.

## STATEMENT OF ELIGIBILITY TO RECEIVE BENEFITS

Individual participating North Dakota Hospitals will each set their own eligibility criteria within Federal Affordable Care Act guidelines.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, an application must be completed. The Claims Administrator may review this initial determination and has full discretion to determine eligibility for benefits. The Claims Administrator's decision shall be final, conclusive and binding upon all parties.

## DESCRIPTION OF BENEFITS

See the Schedule of Benefits and the Covered Services Sections. Refer to the Table of Contents for the Covered Services section page numbers.

## SOURCES OF PREMIUM CONTRIBUTIONS TO THE PLAN AND THE METHOD BY WHICH THE AMOUNT OF CONTRIBUTION IS CALCULATED

Individual participating North Dakota Hospital Association Hospitals will each set their own percentage of premium contribution, remaining within BCBSND requirements, and will individually submit contribution and eligibility forms to BCBSND and the Trust.

## END OF THE YEAR DATE FOR PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS

December 31

**HEALTH BENEFITS**
**TABLE OF CONTENTS**

## INTRODUCTION

Benefits described in this Benefit Plan are available to Members and cannot be transferred or assigned. Any attempt to transfer or assign the benefits of this Benefit Plan to ineligible persons will result in automatic termination of this Benefit Plan by the Claims Administrator.

The Plan Administrator believes this Benefit Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Subscriber’s Benefit Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any Cost Sharing Amounts. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Claims Administrator at the telephone number and address on the back of the Member's Identification Card. If this Benefit Plan is affected by ERISA, the Member may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Members may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

The Subscriber will receive an Identification Card displaying the Unique Member Identifier and other information about this Benefit Plan. All Members share this Unique Member Identifier. Carry the Identification Card at all times. If the Identification Card is lost, contact the Claims Administrator to request a replacement. The Subscriber must not let anyone other than an Eligible Dependent use the Identification Card. If another person is allowed to utilize the Identification Card, the Member's coverage will be terminated.

Present your Identification Card to your Health Care Provider to identify yourself as a Member. Participating Health Care Providers will submit claims on your behalf. You will be notified in writing by the Claims Administrator of benefit payments made for Covered Services. Please review your Explanation of Benefits and advise the Claims Administrator if you were billed for services you did not receive.

If you receive services from a Health Care Provider that will not submit claims on your behalf, you are responsible for the submission of a written notice of a claim for the services you received within 12 months after the date the services were provided. The written notice must include information necessary for the Claims Administrator to determine benefits.

The Subscriber hereby expressly acknowledges and understands that Blue Cross Blue Shield of North Dakota is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Cross Blue Shield of North Dakota to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that Blue Cross Blue Shield of North Dakota is not contracting as an agent of the Association. The Subscriber further acknowledges and agrees this Benefit Plan was not entered into based upon representations by any person or entity other than Blue Cross Blue Shield of North Dakota and that no person, entity, or organization other than Blue Cross Blue Shield of North Dakota shall be held accountable or liable to the Subscriber for any of Blue Cross Blue Shield of North Dakota's obligations to the Subscriber created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross Blue Shield of North Dakota other than those obligations created under other provisions of this Benefit Plan.

## MEMBER RIGHTS AND RESPONSIBILITIES

As a Member you have the right to:

- Receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age or sex.
- Be treated with respect, dignity and privacy.
- Privacy of your personal health information that the Claims Administrator maintains in accordance with federal and state laws.
- Be informed about your health condition and to receive information regarding treatment options and their risk in order to make an informed choice regardless of cost or benefit coverage.
- Participate with your Health Care Providers about decisions regarding your treatment, including the right to refuse treatment.
- Make recommendations regarding this Member's rights and responsibilities statement.
- File a complaint or an appeal about your health plan or the services it delivers. You may do so by contacting Member Services at the telephone number on the back of your Identification Card.
- Receive information about the Claims Administrator, its products and services, its Participating Providers, and your rights and responsibilities.

As a Member you have the responsibility to:

- Know your health plan benefits and requirements.
- Timely advise the Claims Administrator of any changes that affect you or your family, such as a birth, marriage/divorce or change of address.
- Provide the necessary information to your Health Care Providers needed to determine appropriate care.
- Follow the treatment plan prescribed by your Health Care Provider.
- Timely provide the Claims Administrator the necessary information to process your claims and provide you with the benefits available to you under your plan.

## SECTION 1
## SCHEDULE OF BENEFITS

This section outlines the payment provisions for Covered Services described in Section 2, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

The Claims Administrator shall have full discretion to interpret and determine the application of the Schedule of Benefits in each and every situation. Any decisions by the Claims Administrator regarding the Schedule of Benefits shall be final, conclusive and binding upon all parties.

### 1.1 COST SHARING AMOUNTS

Cost Sharing Amounts include Coinsurance, Copayment, Deductible, Prescription Medication or Drug Coinsurance Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. A Member is responsible for the Cost Sharing Amounts. Please see Section 1.5, Outline of Covered Services, for the specific Cost Sharing Amounts that apply to this Benefit Plan. All Members contribute to the Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Individual Participation amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided.

If the Claims Administrator pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles, Copayments or Coinsurance Amounts, the Claims Administrator may collect such amounts directly from the Member. The Member agrees that the Claims Administrator has the right to collect such amounts from the Member.

**Under this Benefit Plan the Deductible Amounts are:**

| | |
|---|---|
| Individual Participation | $500 per Benefit Period |
| Parent and Child Participation | $750 per Benefit Period |
| Parent and Children Participation | $750 per Benefit Period |
| Two Person Participation | $1,000 per Benefit Period |
| Family Participation | $1,000 per Benefit Period |

**Under this Benefit Plan the Coinsurance Maximum Amounts are:**

| | |
|---|---|
| Individual Participation | $1,500 per Benefit Period |
| Parent and Child Participation | $2,250 per Benefit Period |
| Parent and Children Participation | $2,250 per Benefit Period |
| Two Person Participation | $3,000 per Benefit Period |
| Family Participation | $3,000 per Benefit Period |

**Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:**

| | |
|---|---|
| Individual Participation | $2,000 per Benefit Period |
| Parent and Child Participation | $3,000 per Benefit Period |
| Parent and Children Participation | $3,000 per Benefit Period |
| Two Person Participation | $4,000 per Benefit Period |
| Family Participation | $4,000 per Benefit Period |

**Under this Benefit Plan the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount is:**

$1,000 per Member per Benefit Period

**Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:**

$500 per Member

## 1.2 LIFETIME MAXIMUM

The Lifetime Maximum for this Benefit Plan is unlimited, except for specific Covered Services as listed in the Outline of Covered Services.

## 1.3 SELECTING A HEALTH CARE PROVIDER

This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with the Claims Administrator:

### A. Participating Health Care Providers

When Covered Services are received from a Participating Health Care Provider, the Participating Health Care Provider agrees to submit claims to the Claims Administrator on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider according to the terms of this Benefit Plan and the participation agreement between the Health Care Provider and the Claims Administrator.

When Covered Services are received from a Participating Health Care Provider, a provider discount provision is in effect. This means the Allowance paid by the Claims Administrator will be considered by the Participating Health Care Provider as payment in full, except for Cost Sharing Amounts, Maximum Benefit Allowances or Lifetime Maximums.

Participating Health Care Providers have also agreed to perform authorization requirements on behalf of the Member.

To view the provider directory, visit www.BCBSND.com.

### B. Nonparticipating Health Care Providers

If a Member receives Covered Services from a Nonparticipating Health Care Provider, the Member will be responsible for notifying the Claims Administrator of the receipt of services by submitting a claim within 12 months after the date of the services. The written notice must include information necessary for the Claims Administrator to determine benefits. If the Claims Administrator needs copies of medical records to process the Member's claim, the Member is responsible for obtaining such records from the Nonparticipating Health Care Provider. In addition, the Member will be responsible for compliance with all required authorization provisions. See Section 3, Authorizations.

1. Nonparticipating Health Care Providers Within the State of North Dakota

   If a Member receives Covered Services from a Nonparticipating Health Care Provider within the state of North Dakota, benefit payments will be based on the Allowance.

   **The Member is responsible for any charges in excess of the Allowance for Covered Services.**

   Benefit payments will be made directly to the Subscriber for Covered Services received from a Nonparticipating Health Care Provider. The Claims Administrator will not honor an assignment of benefit payments to any other person or Health Care Provider.

2. Nonparticipating Health Care Providers Outside the State of North Dakota

   If a Member receives Covered Services from a Nonparticipating Health Care Provider outside the state of North Dakota, the Allowance for Covered Services will be an amount within a general range of payments made and judged to be reasonable by the Claims Administrator.

   **The Member is responsible for any charges in excess of the Allowance for Covered Services.**

   If a Member receives Covered Services from a Health Care Provider in a county contiguous to North Dakota, the benefit payment will be provided on the same basis as a Health Care Provider located in the state of North Dakota. If the Health Care Provider is a Participating Health Care Provider, the benefit payment will be as indicated in the Outline of Covered Services. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Nonparticipating Health Care Providers within the state of North Dakota.

   Payment for Covered Services received from out-of-state Health Care Providers will be made directly to the Subscriber unless a special arrangement exists between the Claims Administrator and the Health Care Provider. The Claims Administrator may designate an out-of-state Health Care Provider as Nonpayable.

   An assignment of payment to an out-of-state Health Care Provider must be in writing, filed with each claim and approved by the Claims Administrator.

3. Nonparticipating Health Care Providers - Protections from Certain Excess Charges

   In certain situations, a Member will receive the higher level of benefits under this Benefit Plan even though the Member receives Covered Services from a Nonparticipating Health Care Provider. These situations include:

   - Emergency Services.
   - Covered Services including anesthesia, radiology, pathology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services from a Nonparticipating Health Care Provider in a Participating Health Care Provider setting.
   - Air transportation.

   Precertification requirements do not apply to Emergency Services.

   Reimbursement for Covered Services will be made directly to the Nonparticipating Health Care Provider. The Allowance paid by the Claims Administrator will be considered by the Nonparticipating Health Care Provider as payment in full, except for Cost Sharing Amounts, Maximum Benefit Allowances or Lifetime Maximums.

   A Member will be responsible for Cost Sharing Amounts at the higher level of benefits as if the Covered Services had been received from a Participating Health Care Provider.

C. **Nonpayable Health Care Providers**

   If the Claims Administrator designates a Health Care Provider as Nonpayable, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the Nonpayable Health Care Provider. Notice of designation as a Nonpayable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Nonpayable Health Care Provider. As of the date of termination, all charges incurred by a Member for services received from the Nonpayable Health Care Provider will be the Subscriber's responsibility.

D. **Inter-Plan Arrangements**

BCBSND has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Member obtains health care services outside of the geographic area BCBSND serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When a Member receives care outside of the BCBSND service area, the Member will receive care from one of two kinds of Health Care Providers. Most Health Care Providers ("Participating Health Care Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Health Care Providers ("Nonparticipating Health Care Providers") do not contract with the Host Blue. Below BCBSND explains how BCBSND pays both kinds of Health Care Providers.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits and vision care benefits (except when paid as medical claims/benefits), and those prescription drug benefits that may be administered by a third party contracted by BCBSND to provide the specific service or services.

1. **BlueCard® Program**

Under the BlueCard Program, when a Member accesses health care services within the geographic area serviced by a Host Blue, BCBSND will remain responsible for fulfilling BCBSND's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

When a Member obtains health care services outside the geographic area BCBSND serves and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services is calculated on the **lower** of:

- The Host Blue's participating health care provider's billed charges, or
- The negotiated price that the Host Blue makes available to BCBSND.

Often, this "negotiated price" will be a simple discount that reflects an actual price paid by the Host Blue. Sometimes it is an estimated price that takes into account special arrangements with a health care provider or with a specified group of health care providers that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSND uses for the Member's claim because they will not be applied after a claim is already paid.

2. **Value-Based Programs**

If a Member receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSND through average pricing or fee schedule adjustments.

For the purpose of this provision, the following definitions apply:

a. Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's health care needs across the continuum of care.

b. Care Coordinator Fees: A fixed amount paid by a Blue Cross and/or Blue Shield Plan to health care providers periodically for Care Coordination under a Value-Based Program.

c. Provider Incentive: An additional amount of compensation paid to a health care provider by a Blue Cross and/or Blue Shield Plan, based on the health care provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

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

3. **Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSND will include any such surcharge, tax or other fee as part of the claim charge passed on to the Member.

4. **Nonparticipating Health Care Providers Outside the BCBSND Service Area**

When Covered Services are provided outside of BCBSND's service area by Nonparticipating Health Care Providers, the amount the Member pays for such services will generally be based on either the Host Blue's Nonparticipating Health Care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the Nonparticipating Health Care Provider bills and the payment BCBSND will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services, certain out-of-network services furnished by a Nonparticipating Health Care Provider in an in-network setting and out-of-network air transportation.

In certain situations, BCBSND may use other payment bases, such as the payment BCBSND would make if the Covered Services had been obtained within the BCBSND service area, or a special negotiated payment to determine the amount BCBSND will pay for Covered Services provided by Nonparticipating Health Care Providers. In these situations, a Member may be liable for the difference between the amount that the Nonparticipating Health Care Provider bills and the payment BCBSND will make for the Covered Services as set forth in this paragraph.

For further information on Nonparticipating Health Care Providers within the BCBSND service area, see the Nonparticipating Health Care Providers section under Selecting a Health Care Provider in Section 1 of the Benefit Plan.

5. **Blue Cross Blue Shield Global® Core**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue.

If a Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

a. **Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for Cost Sharing Amounts. In such cases, the hospital will submit the Member's claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services.

b. **Outpatient Services**

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

c. **Submitting a Blue Cross Blue Shield Global Core Claim**

When a Member pays for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the health care provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSND, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If a Member needs assistance with claim submissions, the Member should call the Blue Cross Blue Shield Global Core Service Center.

E. **Health Care Providers Outside the United States**

The benefits available under this Benefit Plan are also available to Members traveling or living outside of the United States. The Precertification requirements will apply. See the Blue Cross Blue Shield Global Core section above for further information on services received outside the United States.

The Claims Administrator will reimburse Prescription Medications or Drugs purchased outside the United States by Members who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Members are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

F. **Medicare Private Contracts**

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services and indicate that neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider and that the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge. Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and the Claims Administrator will limit its payment to the amount the Claims Administrator would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by the Claims Administrator.

## 1.4 CONTINUITY OF CARE

If a Member is receiving an active course of treatment care from a Participating Health Care Provider who becomes a Nonparticipating Health Care Provider during the active course of treatment, the Claims Administrator will authorize continuity of care at the Participating Health Care Provider level for the following conditions or situations:

A. Continuation for up to 90 days:
   1. Active institutional or Inpatient care;
   2. Active treatment (radiation, chemotherapy, surgery) for cancer;
   3. Active treatment for severe or end stage kidney disease or dialysis;
   4. Active treatment for mental health or substance abuse services;
   5. A serious acute condition, serious complex condition or other life threatening condition;
   6. Non-elective surgeries; or
   7. Terminal illness.

B. Continuation through the first postpartum visit:
   1. A pregnancy beyond the first trimester; or
   2. A high risk pregnancy.

C. Continuation for up to 1 year:
   1. A transplant or on a waiting list to receive a transplant.

D. Continuation as long as the individual is a Member under this Benefit Plan:
   1. Receiving active treatment for Human Immunodeficiency Virus (HIV) or Symptomatic Acquired Immunodeficiency Syndrome (AIDS).

The Member or the Member's Authorized Representative must submit a written request for continuity of care to the Claims Administrator within 180 days of the first day the Health Care Provider is deemed a Nonparticipating Health Care Provider.

Benefit payment will be made directly to the Subscriber for Covered Services received from the Nonparticipating Health Care Provider.

For further information, please contact Member Services at the telephone number and address on the back of the Identification Card.

## 1.5 OUTLINE OF COVERED SERVICES

**The benefit amounts specified in this outline apply only to Covered Services received from Participating Health Care Providers. Benefit amounts for Covered Services received from a Nonparticipating Health Care Provider differ as described in Section 1.3, Selecting a Health Care Provider.**

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| **Inpatient Hospital and Medical Services** | |
| • Inpatient Hospital Services | 80% of Allowed Charge. |
| • Inpatient Medical Care Visits | 80% of Allowed Charge. |
| • Ancillary Services | 80% of Allowed Charge. |
| • Inpatient Consultations | 80% of Allowed Charge. |
| • Concurrent Services | 80% of Allowed Charge. |
| • Initial Newborn Care | 80% of Allowed Charge. Deductible Amount is waived for the first 30 days following the date of birth. |
| **Inpatient and Outpatient Surgical Services** | |
| • Professional Health Care Provider Services | 80% of Allowed Charge. |
| • Assistant Surgeon Services | 80% of Allowed Charge. |
| • Ambulatory Surgical Facility Services | 80% of Allowed Charge. |
| • Hospital Ancillary Services | 80% of Allowed Charge. |
| • Anesthesia Services | 80% of Allowed Charge. |
| • Bariatric Surgery | 80% of Allowed Charge subject to a Lifetime Maximum of 1 operative procedure per Member when Precertification is received from the Claims Administrator. |
| **Transplant Services** | Benefits are subject to a Lifetime Maximum of 2 transplant procedures for the same condition. |
| • Inpatient and Outpatient Hospital and Medical Services | 80% of Allowed Charge when Precertification is received from the Claims Administrator. |
| • Transportation Services | 80% of Allowed Charge subject to a Maximum Benefit Allowance of $1,000 per transplant procedure. |
| **Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment** | 80% of Allowed Charge.<br><br>Benefits are subject to a Lifetime Maximum of 2 surgical procedures and a Maximum Benefit Allowance of 1 splint per Member per Benefit Period. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| **Outpatient Hospital and Medical Services** | |
| • Home and Office Visits | $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| • Diagnostic Services | 80% of Allowed Charge. |
| • Emergency Services | $75 Copayment Amount, then 80% of Allowed Charge for emergency room facility fee. Deductible Amount is waived.<br><br>$25 Copayment Amount, then 80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. Deductible Amount is waived.<br><br>80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office. |
| • Dental Services | |
| Dental Services including frenotomy, frenectomy, oral biopsy, oral lesion removal, oral abscess treatment, tooth extractions in preparation for radiation treatment | 80% of Allowed Charge. |
| Accidental Injury | 80% of Allowed Charge. |
| Dental Anesthesia and Hospitalization | 80% of Allowed Charge. Precertification is required for all Members age 9 and older. |
| • Preadmission Testing Services | |
| Diagnostic Services | 80% of Allowed Charge. |
| Related Office Visit | $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| • Second Surgical Opinions | |
| Diagnostic Services | 80% of Allowed Charge. |
| Related Office Visit | $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| • Radiation Therapy and Chemotherapy | 80% of Allowed Charge. |
| • Dialysis Treatment | 80% of Allowed Charge. |
| • Home Infusion Therapy Services | 80% of Allowed Charge. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| • Visual Training for Members under age 10 | 80% of Allowed Charge subject to a Lifetime Maximum of 16 visits per Member. |
| • Allergy Services | 80% of Allowed Charge. |
| • Phenylketonuria (PKU) - Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU) | 80% of Allowed Charge. |
| **Wellness Services** | |
| • Pediatric Preventive Visits for Members through age 6 | $25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.<br><br>Benefits are available as follows:<br><br>• 11 visits for Members from birth through 35 months;<br><br>• 1 visit per Benefit Period for Members age 3 through age 6. |
| • Pediatric Preventive Immunizations through age 6 | 100% of Allowed Charge. Deductible Amount is waived.<br><br>Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease and Influenza Virus. |
| • Breast Cancer Screening | |
| Mammography with or without Digital Breast Tomosynthesis Screening (3D Mammography) | 80% of Allowed Charge. Deductible Amount is waived.<br><br>• One service for Members between the ages of 35 and 40;<br><br>• One service per year for Members age 40 and older.<br><br>Additional benefits will be available for mammography services when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| • Routine Pap Smear | 80% of Allowed Charge subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period. Deductible Amount is waived. |
| Related Office Visit | $25 Copayment Amount for the Office Visit, then 80% of Allowed Charge. Deductible Amount is waived.<br><br>Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services. |
| • Prostate Cancer Screening for Members age 40 and older | 80% of Allowed Charge. Deductible Amount is waived. |
| Related Office Visit | $25 Copayment Amount for the Office Visit, then 80% of Allowed Charge. Deductible Amount is waived.<br><br>Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Outpatient Hospital and Medical Services. |
| • Fecal Occult Blood Testing for Colorectal Cancer Screening | 80% of Allowed Charge for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period. Deductible Amount is waived. |
| • Immunizations other than Pediatric Preventive | 100% of Allowed Charge. Deductible Amount is waived.<br><br>Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply. |
| • Outpatient Nutrition Care Services (Including Feeding and Eating Disorders) | $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions:<br><br>• Hyperlipidemia – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period.<br><br>• Gestational Diabetes – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| | • Chronic Renal Failure – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.<br><br>• Diabetes Mellitus – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.<br><br>• PKU – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.<br><br>• Obesity – Maximum Benefit Allowance of 1 Office Visit per Member per Benefit Period.<br><br>• Celiac Disease – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period. |
| • Diabetes Education Services | 80% of Allowed Charge. Deductible Amount is waived. |
| • Diabetes Prevention Program for Members age 18 and older | 100% of Allowed Charge. Deductible Amount is waived. |
| • Comprehensive Eye Examination with Dilation | $25 Copayment Amount, then 80% of Allowed Charge subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period. Deductible Amount is waived. |
| • Tobacco Cessation Services<br><br>Prescription Non-Nicotine Replacement Therapy<br><br>Payable Over-the-Counter (OTC) Nicotine Replacement Therapy (nicotine lozenges, patches, gum)<br><br>Prescription Nicotine Replacement Therapy (nicotine nasal spray, inhaler, patches) | Tobacco cessation services obtainable with a Prescription Order are paid under the Outpatient Prescription Medications or Drugs benefit. |
| Related Office Visit | $25 Copayment Amount for the Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| **Outpatient Therapy Services** | |
| • Rehabilitative Therapy<br><br>Physical Therapy<br><br>Occupational Therapy<br><br>Speech Therapy | $20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| • Habilitative Therapy<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy | $20 Copayment Amount per visit, then 80% of Allowed Charge subject to a Maximum Benefit Allowance of 90 visits per therapy per Member per Benefit Period. Deductible Amount is waived. Psychiatric and substance abuse services are excluded from the Maximum Benefit Allowance. |
| • Other Therapy Services | |
| Respiratory Therapy Services | 80% of Allowed Charge. |
| Cardiac Rehabilitation Services | 80% of Allowed Charge. Deductible Amount is waived. |
| Pulmonary Rehabilitation Services | 80% of Allowed Charge. Deductible Amount is waived. |
| **Chiropractic Services** | Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider. |
| • Home and Office Visits | $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| • Therapy and Manipulations | $20 Copayment Amount per visit, then 80% of Allowed Charge. Deductible Amount is waived. |
| • Diagnostic Services | 80% of Allowed Charge. |
| **Maternity Services** | |
| • Inpatient Hospital and Medical Services | 80% of Allowed Charge. |
| • Prenatal and Postnatal Care | 80% of Allowed Charge. Deductible Amount is waived. |
| **Infertility Services** | 80% of Allowed Charge subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Maximum per Member. This Coinsurance Amount and the Infertility Services Deductible Amount do not apply toward the Out-of-Pocket Maximum Amount. Precertification is required. |
| **Psychiatric and Substance Abuse Services** | |
| • Psychiatric Services | |
| Inpatient | 80% of Allowed Charge. Precertification may be required. |
| Residential Treatment | 80% of Allowed Charge. Precertification is required. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| Partial Hospitalization | 80% of Allowed Charge. |
| Intensive Outpatient Program | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 hours per Member per Benefit Period.<br><br>Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to the Deductible Amount. |
| Outpatient | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 hours per Member per Benefit Period. Precertification may be required. |
| Home and Office Visits Including assessment, counseling, case management services, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy | Covered Services received during the remainder of the Benefit Period are subject to a $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. Precertification may be required. |
| Outpatient Services Including diagnostic testing, diagnostic procedures and treatment procedures | Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to the Deductible Amount. Precertification may be required. |
| • Substance Abuse Services | |
| Inpatient | 80% of Allowed Charge. Precertification may be required. |
| Residential Treatment | 80% of Allowed Charge. Precertification is required. |
| Partial Hospitalization | 80% of Allowed Charge. |
| Intensive Outpatient Program | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 visits per Member per Benefit Period.<br><br>Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to the Deductible Amount. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| Outpatient | 100% of Allowed Charge and Deductible Amount is waived for the initial 5 visits per Member per Benefit Period. Precertification may be required. |
| Home and Office Visits Including assessment, counseling, case management services, treatment planning, coordination of care, psychotherapy and group therapy, Opioid Treatment Program and Peer Support | Covered Services received during the remainder of the Benefit Period are subject to a $25 Copayment Amount per Office Visit, then 80% of Allowed Charge. Deductible Amount is waived. Precertification may be required. |
| Outpatient Services Including diagnostic testing, diagnostic procedures and treatment procedures | Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to the Deductible Amount. Precertification may be required. |
| **Ambulance Services** | |
| • Ground Ambulance | 80% of Allowed Charge. |
| • Air Ambulance | 80% of Allowed Charge. Precertification may be required. |
| **Skilled Nursing Facility Services** | 80% of Allowed Charge. |
| **Home Health Care Services** | 80% of Allowed Charge. |
| **Hospice Services** | 80% of Allowed Charge. |
| **Private Duty Nursing Services** | 80% of Allowed Charge. |
| **Medical Supplies and Equipment**<br>• Home Medical Equipment<br>• Prosthetic Appliances and Limbs<br>• Orthotic Devices<br>• Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Outpatient Prescription Medications or Drugs<br>• Oxygen Equipment and Supplies<br>• Ostomy Supplies | 80% of Allowed Charge. |
| • Hearing aids for Members under age 18 | Subject to a Maximum Benefit Allowance per Member of 1 hearing aid per ear every 3 years. |
| **Eyeglasses or Contact Lenses**<br>(following a covered cataract surgery) | 80% of Allowed Charge subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery. |

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| **Telehealth** | Covered Services delivered by means of Telehealth are subject to the Cost Sharing Amounts listed throughout the Outline of Covered Services. |
| **Outpatient Prescription Medications or Drugs and Diabetes Supplies** | |
| **Retail Pharmacy** | |
| • Formulary Drug | $15 Copayment Amount, then 80% of Allowed Charge. Benefits are subject to the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. Deductible Amount is waived. |
| • Nonformulary Drug | $15 Copayment Amount and 50% sanction. The sanction is 50% of the Allowed Charge. This sanction does not apply to any Cost Sharing Amounts and coordination of benefits will not be allowed. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. |
| **Preferred Mail Order Pharmacy** | |
| • Formulary Drug | $15 Copayment Amount, then 80% of Allowed Charge. Benefits are subject to the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. Deductible Amount is waived. |
| • Nonformulary Drug | $15 Copayment Amount and 50% sanction. The sanction is 50% of the Allowed Charge. This sanction does not apply to any Cost Sharing Amounts and coordination of benefits will not be allowed. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. |

Note: A Member may choose to utilize a preferred mail order pharmacy. The preferred mail order pharmacy offers a discounted pricing program for a Member who chooses not to use the mail order prescription coverage under this Benefit Plan. The preferred mail order pharmacy will provide both the Member's Cost Sharing Amount for mail order prescription coverage under this Benefit Plan and the full purchase prices of the mail order prescription under the discounted pricing program. The discounted pricing program is not insurance. If a Member chooses to purchase the mail order prescription through the discounted pricing program, the Member is responsible for the payment in full at the time of the purchase. When a Member purchases a mail order prescription through the discounted pricing program, a portion of the Member's purchase price may be applied to the Out-of-Pocket Maximum Amount depending on the discounted pricing program guidelines in effect at the time of the purchase.

| Covered Services | The Claims Administrator Pays After Deductible and Applicable Copayment Amounts |
|---|---|
| **Specialty Pharmacy** | |
| • Formulary Drug | $15 Copayment Amount, then 80% of Allowed Charge. Benefits are subject to the Outpatient Prescription Medication or Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. Deductible Amount is waived. |
| • Nonformulary Drug | $15 Copayment Amount and 50% sanction. The sanction is 50% of the Allowed Charge. This sanction does not apply to any Cost Sharing Amounts and coordination of benefits will not be allowed. Benefits are subject to the Copayment Amount application listed below. Deductible Amount is waived. |

Note: Specialty Drugs must be received from the preferred specialty pharmacy network.

**Copayment Amount Application:**

**Retail Pharmacy**
One Copayment Amount per Prescription Order or refill for a 1 – 34-day supply.
Two Copayment Amounts per Prescription Order or refill for a 35 – 60-day supply.
Three Copayment Amounts per Prescription Order or refill for a 61 – 100-day supply.

**Preferred Mail Order Pharmacy**
One Copayment Amount per Prescription Order or refill for a 1 – 34-day supply.
Two Copayment Amounts per Prescription Order or refill for a 35 – 60-day supply.
Three Copayment Amounts per Prescription Order or refill for a 61 – 100-day supply.

**Specialty Pharmacy**
One Copayment Amount per Prescription Order or refill for a 1 – 34-day supply.
Two Copayment Amounts per Prescription Order or refill for a 35 – 100-day supply.

**Dispensing Limits**
Prescription Medications or Drugs and diabetes supplies are subject to a dispensing limit of a 100-day supply.

Copayment Amounts do not apply to the following diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

Self-Administered Chemotherapy Prescription Medications or Drugs are paid at 100% of Allowed Charge. Cost Sharing Amounts are waived.

If a Generic Prescription Medication or Drug is the therapeutic equivalent for a Brand Name Prescription Medication or Drug and is authorized by a Member's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication or Drug and applicable Cost Sharing Amounts.

Prescription Medication or Drug Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

To view a list of Participating Pharmacies, visit www.BCBSND.com.

## SECTION 2
## COVERED SERVICES

This section describes the services for which benefits are available for Medically Appropriate and Necessary services under this Benefit Plan, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan, Cost Sharing Amounts, Maximum Benefit Allowances and Lifetime Maximums described in the Schedule of Benefits.

The Claims Administrator shall have full discretion to interpret and determine the application of the Covered Services in each and every situation. Any decisions by the Claims Administrator regarding the Covered Services shall be final, conclusive and binding upon all parties.

### 2.1 INPATIENT HOSPITAL AND MEDICAL SERVICES

Precertification may be required for Inpatient Hospital Admissions. See Section 3, Authorizations.

A. Inpatient Hospital Services include:

1. Bed, board and general nursing services.

2. Special Care Units when Medically Appropriate and Necessary.

3. Long Term Acute Care Facility, Rehabilitation Facility or Transitional Care Unit when Medically Appropriate and Necessary.

4. Ancillary Services when Medically Appropriate and Necessary, Including:

   a. use of operating, delivery and treatment rooms;
   b. prescribed drugs;
   c. blood, blood substitutes and the administration of blood and blood processing;
   d. anesthesia and related supplies and services provided by an employee of or a person under contractual agreement with a Hospital;
   e. medical and surgical dressings, supplies, casts and splints;
   f. Diagnostic Services; and
   g. Therapy Services.

5. Dental anesthesia and hospitalization for dental care to Members under age 9, Members who are severely disabled or Members who have a medical condition that requires hospitalization or general anesthesia. Precertification is required for all Members age 9 and older.

B. Inpatient Medical Services include:

1. Inpatient medical care visits by a Professional Health Care Provider, including those delivered by means of Telehealth, except inpatient stays related to surgery or maternity care. See Section 2.2, Inpatient and Outpatient Surgical Services and Section 2.9, Maternity Services.

2. Consultation services by another Professional Health Care Provider, including those delivered by means of Telehealth, at the request of the attending Professional Health Care Provider for the purpose of advice, diagnosis or instigation of treatment requiring special skill or knowledge. Benefits are available only if a written report from a consultant is a part of the Member's medical records. Consultation benefits do not include staff consultations required by hospital rules and regulations.

3. Concurrent services Including medical, surgical, maternity, Chemotherapy or Radiation Therapy provided during one inpatient stay by one Professional Health Care Provider. Benefits for concurrent services will be based on the Covered Service with the highest Allowance.

   When two or more Professional Health Care Providers have attended the Member during one inpatient stay because the nature or severity of the Member's condition requires the skills of separate Professional Health Care Providers, benefits will be available for the Covered Service that carries the highest Allowance for the type of service provided by each Professional Health Care Provider, provided the service is Medically Appropriate and Necessary and would otherwise be a Covered Service under this Benefit Plan.

4. Routine nursery care and the initial inpatient examination of the newborn child by a Professional Health Care Provider, if the newborn child is a Member. The newborn child is also entitled to benefits from the moment of birth for any illness, accident, deformity or congenital conditions.

## 2.2 INPATIENT AND OUTPATIENT SURGICAL SERVICES

A. Inpatient Surgical Services include:

   1. Surgical Services provided by a Professional Health Care Provider. Separate benefit payments will not be made for preoperative and postoperative services. Payment for these services is included in the surgical fee.

   2. Assistant surgeon services by a Professional Health Care Provider who actively assists the operating surgeon in the performance of covered surgery if the type of surgery performed requires an assistant, as determined by the Claims Administrator, and no Hospital or Ambulatory Surgical Facility staff is available to provide such assistance.

   3. Administration of Medically Appropriate and Necessary anesthesia for a covered surgical procedure when ordered by the attending Professional Health Care Provider and provided by or under the direct supervision of an Anesthesiologist or Professional Health Care Provider other than the operating surgeon or the assistant surgeon.

B. The benefits described above are also available for Outpatient Surgical Services in addition to:

   1. Supplies used for a covered surgical procedure when performed in a Professional Health Care Provider's office, clinic or Ambulatory Surgical Facility.

   2. Facility charges for covered outpatient Surgical Services performed in an Ambulatory Surgical Facility.

   3. Hospital Ancillary Services and supplies used for a covered outpatient surgery, Including removal of sutures, anesthesia and related supplies and services when provided by an employee of or under contractual agreement with the Hospital, other than the surgeon or assistant at surgery.

C. Benefits are available for the following special surgeries:

   1. Reconstructive surgery to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

      Benefits include reconstructive breast surgery performed as a result of a partial or total mastectomy subject to Benefit Plan Cost Sharing Amounts. Benefits also include reconstructive breast surgery on the nondiseased breast to establish symmetry with the reconstructed diseased breast. Benefits for prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, are allowed under Section 2.17, Medical Supplies and Equipment. Benefits will be allowed in a manner determined in consultation with the attending Professional Health Care Provider and the Member.

      Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition.

2. Sterilization procedures. Procedures to evaluate and reverse sterilization are not covered under this Benefit Plan.

3. Bariatric surgery when Precertification is received from the Claims Administrator. Benefits are subject to a Lifetime Maximum of 1 bariatric surgery per Member. Guidelines and criteria are available upon request.

   Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of bariatric surgery are available only when Precertification is received from the Claims Administrator.

## 2.3 TRANSPLANT SERVICES

A. Subject to the exclusions of this Benefit Plan, benefits are available for the following transplant procedures based on medical criteria if the recipient is a Member under this Benefit Plan. Benefits are not available under this Benefit Plan if the Member is the donor for transplant services. Benefits are subject to a Lifetime Maximum of 2 transplant procedures for the same condition. Precertification is required.

   1. Heart
   2. Heart-lung
   3. Lung (single or double)
   4. Liver
   5. Pancreas
   6. Small bowel
   7. Kidney
   8. Cornea
   9. Bone marrow/stem cell transplants with related services and supplies are covered subject to medical policy or medical guidelines.

   Please contact the Claims Administrator to ensure benefits are available for specific transplant procedures. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

   **If a Member chooses to receive Covered Services from a program not approved by the Claims Administrator, the Member will be responsible for any charges over the Allowance.**

B. Covered Services include:

   1. One evaluation is allowed per transplant procedure. Services must be performed at a qualified transplant center.

   2. Inpatient and outpatient Hospital and Medical Services for the recipient and the donor.

   3. Surgical Services Including the evaluation and removal of the donor organ as well as transplantation of the organ or tissue into the recipient. Separate payment will not be made for the removal of an organ for transplantation at a later date.

   4. Compatibility testing services provided to the donor.

   5. Supportive medical procedures and clinical management services, Including postoperative procedures to control rejection and infection.

   6. Transportation costs by air ambulance, commercial carrier or charter when a Member must be transported within a restricted time frame to obtain a covered transplant procedure. Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

C. Benefits are not available for artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

## 2.4 TEMPOROMANDIBULAR OR CRANIOMANDIBULAR JOINT TREATMENT

Temporomandibular (TMJ) or craniomandibular (CMJ) joint treatment, Including surgical and nonsurgical services, when such care and treatment is Medically Appropriate and Necessary as determined by the Claims Administrator. Benefits are subject to the Lifetime Maximum and the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

## 2.5 OUTPATIENT HOSPITAL AND MEDICAL SERVICES

Outpatient Hospital and Medical Services include:

A. Home and Office Visits and consultations, including those delivered by means of Telehealth, for the examination, diagnosis and treatment of an illness or injury, Including administered Prescription Medications or Drugs.

B. Diagnostic Services when ordered by a Professional Health Care Provider.

C. Emergency Services.

D. Dental services provided by a Physician, Qualified Healthcare Practitioner (QHP), Oral Surgeon or Dentist (D.D.S.) in an office setting, including extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw, frenotomy, frenectomy, oral biopsy, oral lesion removal, oral abscess treatment or as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. Covered Services for the jaw, sound natural teeth, dentures, mouth or face as a result of an accidental injury must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by the Claims Administrator is in place. An accidental injury is defined as an injury that is the result of an external force causing a specific impairment to the jaw, sound natural teeth, dentures, mouth or face. Injury as a result of chewing or biting is not considered an accidental injury.

E. Surgical preadmission testing for Medically Appropriate and Necessary preoperative tests and studies provided on an outpatient basis prior to a Member's scheduled Admission to the Hospital as an Inpatient for surgery.

   Benefits are available only under the following conditions:

   1. The tests or studies would have been provided on an inpatient basis for the same condition; and

   2. The tests or studies are not repeated upon the Member's Admission to the Hospital.

F. Second surgical opinion consultations on covered elective surgery recommended by a Health Care Provider and those directly related Diagnostic Services required for a valid second surgical opinion. A second surgical opinion must be provided by a Professional Health Care Provider qualified to perform the suggested surgery and whose practice is unrelated to the Member's original Health Care Provider.

G. Radiation and Chemotherapy Services, except as limited by this Benefit Plan.

H. Dialysis Treatment.

I. Home Infusion Therapy services. Covered Services include the provision of nutrients, antibiotics, and other drugs and fluids intravenously, through a feeding tube, or by inhalation; all Medically Appropriate and Necessary supplies; and therapeutic drugs or other substances. Covered Services also include Medically Appropriate and Necessary enteral feedings when such feedings are the primary source of nutrition for a Member age 1 and older.

J. Visual training services, Including orthoptics and pleoptic training, provided to Members under age 10 for the treatment of amblyopia. Benefits are subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.

K. Allergy Services, Including serum, direct skin testing and patch testing when ordered by a Professional Health Care Provider and performed in accordance with medical guidelines and criteria established by the Claims Administrator. Guidelines and criteria for Medically Appropriate and Necessary services are available from a Participating Health Care Provider or the Claims Administrator.

L. Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU). The following foods and food products are available:

1. Low protein modified food product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

2. Medical food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a Physician.

M. Dental anesthesia and hospitalization for dental care to Members under age 9, Members who are severely disabled or Members who have a medical condition that requires hospitalization or general anesthesia. Precertification is required for all Members age 9 and older.

## 2.6 WELLNESS SERVICES

A. Pediatric preventive visits and immunizations for Members through age 6 in accordance with the schedule listed in the Schedule of Benefits, Section 1.

B. Mammography screening services in accordance with the schedule listed in the Schedule of Benefits, Section 1.

C. One routine Pap smear per Member per Benefit Period. Benefits include the related Office Visit.

D. Prostate cancer screening services subject to the guidelines listed in the Schedule of Benefits, Section 1. Benefits include the related Office Visit.

E. Fecal occult blood testing for colorectal cancer screening subject to the guidelines listed in the Schedule of Benefits, Section 1.

F. Immunizations that have been published as policy by the Centers for Disease Control as listed in the Schedule of Benefits, Section 1.

G. Outpatient nutrition care services provided by a Licensed Registered Dietitian when ordered by a Professional Health Care Provider. Covered Services include assessment of food practices and dietary/nutritional status and diet counseling for preventive and therapeutic needs for the diagnosed medical conditions listed in the Schedule of Benefits, Section 1.

H. Diabetes care services including:

1. Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutritional Care Services, Diabetes Education Services, Dilated Eye Examinations and Outpatient Prescription Medications or Drugs and Diabetes Supplies.

2. Diabetes Prevention Program services for Members age 18 and older meeting certain medical criteria of having a high risk of developing type 2 diabetes when enrolled through a Diabetes Prevention Provider.

Benefits are subject to the Maximum Benefit Allowances listed in the Schedule of Benefits, Section 1.

I. Tobacco cessation services subject to the guidelines listed in the Schedule of Benefits, Section 1. Benefits include the related Office Visit.

## 2.7 OUTPATIENT THERAPY SERVICES

A. Rehabilitative Therapy

Rehabilitative Physical Therapy, Occupational Therapy and Speech Therapy Services that are designed to restore function following a surgery or medical procedure, injury or illness. Benefits are available as listed in Section 1, Schedule of Benefits, when performed by or under the direct supervision of the respective licensed Physical Therapist, licensed Occupational Therapist or licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider. Benefits are not available for Maintenance Care.

B. Habilitative Therapy

Habilitative Physical Therapy, Occupational Therapy or Speech Therapy is care provided for conditions which have limited the normal age appropriate motor, sensory or communication development. To be considered habilitative, therapy must help maintain or prevent deterioration of functional skills within a predictable period of time toward a Member's maximum potential.

Functional skills are defined as essential activities of daily life common to all Members Including dressing, feeding, swallowing, mobility, transfers, fine motor skills, age appropriate activities and communication. Problems Including hearing impairment, deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism spectrum disorders, traumatic brain injury, deaf-blindness, or multiple disabilities may warrant Habilitative Therapies.

Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1, for each type of therapy under an individual medical plan (IMP) developed for each Member. Extensions of therapy may be granted on a case by case basis for extenuating circumstances.

C. Other Therapy Services

1. Respiratory Therapy services performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of patients with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

2. Cardiac rehabilitation services.

3. Pulmonary rehabilitation services.

## 2.8 CHIROPRACTIC SERVICES

Chiropractic services provided on an inpatient or outpatient basis when Medically Appropriate and Necessary as determined by the Claims Administrator and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician. Benefits are not available for maintenance care.

## 2.9 MATERNITY SERVICES

Benefits are available for Covered Services for pregnancy and complications of pregnancy. Benefits are limited to 2 ultrasounds per pregnancy unless, based on the Member's condition and history, additional services are determined to be Medically Appropriate and Necessary.

Benefits for inpatient maternity services allow a minimum stay of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The Health Care Provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Benefits for Outpatient Nutrition Care Services for Gestational Diabetes are available. See Outpatient Nutrition Care Services in the Schedule of Benefits, Section 1.

If the newborn child is a Member, benefits are available from the moment of birth for routine nursery care and the treatment of any illness, accident, deformity or congenital condition.

**Prenatal Plus Program**

The prenatal plus program is designed to identify women at higher risk for premature birth and to prevent the incidence of preterm birth through assessment, intervention and education. Participation in the prenatal plus program is voluntary.

To participate, the Member must notify a Member Services representative after the first prenatal visit; preferably before the 12th week. The number to call regarding prenatal plus is on the back of the Identification Card. A Member Services representative will obtain the Member's name, Unique Member Identifier and telephone number and request a medical management representative contact the Member.

A medical management representative will review the preterm labor risk assessment questionnaire with the Member. The questionnaire will take approximately ten minutes to complete. The information needed to complete this form is the Member's Unique Member Identifier, Professional Health Care Provider's name, address and telephone number and the Member's expected due date.

As a program participant, the Member will receive a packet containing information concerning pregnancy and prenatal care.

## 2.10 INFERTILITY SERVICES

Benefits are available for services, supplies and drugs related to artificial insemination (AI) and assisted reproductive technology (ART), Including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF), subject to the Cost Sharing Amounts and Lifetime Maximum listed in the Schedule of Benefits, Section 1. Guidelines and criteria for Medically Appropriate and Necessary services are available from the Claims Administrator. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

Precertification is required for assisted reproductive technology for GIFT, ZIFT, ICSI and IVF.

## 2.11 PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

Guidelines and criteria for Medically Appropriate and Necessary services are available from the Claims Administrator.

A. Psychiatric Services

1. Inpatient

Benefits are available for the inpatient treatment of psychiatric illness when provided by an appropriately licensed and credentialed Hospital or Psychiatric Care Facility. Precertification may be required for Inpatient Hospital Admissions. See Section 3, Authorizations.

2. Residential Treatment

   Benefits are available for the Residential Treatment of psychiatric illness when provided at an appropriately licensed and credentialed residential treatment center. Precertification is required.

3. Partial Hospitalization

   Benefits are available for the Partial Hospitalization of psychiatric illness when provided at an appropriately licensed and credentialed facility.

4. Intensive Outpatient Program

   Benefits are available in an Intensive Outpatient Program for psychiatric illness when provided by an appropriately licensed and credentialed Intensive Outpatient Program.

5. Outpatient

   a. Home and Office Visits: Benefits Including assessment, counseling, case management services, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

   b. Outpatient Services: Benefits Including diagnostic testing, diagnostic procedures and treatment procedures provided by a licensed and credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

B. Substance Abuse Services

1. Inpatient

   Benefits are available for the inpatient treatment of substance abuse, including medically managed inpatient detoxification, medically monitored inpatient detoxification, medically managed intensive inpatient treatment or medically monitored intensive inpatient treatment, when provided at an appropriately licensed and credentialed Substance Abuse Facility.

   No benefits are available for social detoxification.

   Precertification may be required for Inpatient Hospital Admissions. See Section 3, Authorizations.

2. Residential Treatment

   Benefits are available for the Residential Treatment of substance abuse when provided at an appropriately licensed and credentialed residential treatment center. Precertification is required.

3. Partial Hospitalization

   Benefits are available for the Partial Hospitalization of substance abuse when provided at an appropriately licensed and credentialed facility.

4. Intensive Outpatient Program

   Benefits are available in an Intensive Outpatient Program for substance abuse when provided by an appropriately licensed and credentialed Intensive Outpatient Program.

5. Outpatient

    a. Home and Office Visits: Benefits Including assessment, counseling, case management services, treatment planning, coordination of care, psychotherapy, group therapy and Opioid Treatment Program provided by a licensed and/or credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

    Benefits are available in an Opioid Treatment Program for opioid use disorder when provided by an appropriately licensed and credentialed Opioid Treatment Program.

    b. Outpatient Services: Benefits Including diagnostic testing, diagnostic procedures and treatment provided by a licensed and credentialed independent provider in accordance with the Health Care Provider's scope of licensure as provided by law. Precertification may be required.

C. **The Claims Administrator may designate an out-of-state Health Care Provider as Nonpayable.**

## 2.12 AMBULANCE SERVICES

Medically Appropriate and Necessary Ambulance Services to the nearest facility equipped to provide the required level of care, including transportation:

- from the home or site of an Emergency Medical Condition.
- between Hospitals.
- between a Hospital and Skilled Nursing Facility.

Benefits for air transportation are available only when ground transportation is not Medically Appropriate and Necessary as determined by the Claims Administrator.

## 2.13 SKILLED NURSING FACILITY SERVICES

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services are also available for Skilled Nursing Services and supplies customarily provided to an Inpatient of a Skilled Nursing Facility when the condition requires daily Skilled Nursing Services that are Medically Appropriate and Necessary and such services can only be provided in a Skilled Nursing Facility. Precertification is required. Benefits are not available for Maintenance Care or Custodial Care.

## 2.14 HOME HEALTH CARE SERVICES

Home Health Care when provided to a Member in the Member's place of residence. The services must be provided on a part-time visiting basis according to a Professional Health Care Provider's prescribed plan of treatment approved by the Claims Administrator prior to Admission to Home Health Care. Precertification is required.

A. Covered Services include:

1. The professional services of an R.N., Licensed Vocational Nurse or L.P.N.;
2. Physical, Occupational or Speech Therapy;
3. Medical and surgical supplies;
4. Administration of prescribed drugs;
5. Oxygen and the administration of oxygen; and
6. Health aide services for a Member who is receiving covered Skilled Nursing Services or Therapy Services.

B. No Home Health Care benefits will be provided for:

1. Dietitian services;
2. Homemaker services;
3. Social worker services;
4. Maintenance Care;
5. Custodial Care;
6. Food or home delivered meals; or
7. Respite care.

## 2.15 HOSPICE SERVICES

The benefits available under this Benefit Plan for Inpatient Hospital and Medical Services, Outpatient Hospital and Medical Services, Therapy Services, Skilled Nursing Facility Services, Home Health Care Services and Private Duty Nursing Services are also available when coordinated or provided through an organized and approved hospice program. Hospice benefits are provided only for the treatment of Members diagnosed with a condition where there is a life expectancy of 6 months or less.

## 2.16 PRIVATE DUTY NURSING SERVICES

Private Duty Nursing Services provided by an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when ordered by a Professional Health Care Provider. The nurse must not ordinarily reside in the Member's home or be a member of the Member's Immediate Family. Benefits are not available for Maintenance Care.

## 2.17 MEDICAL SUPPLIES AND EQUIPMENT

Benefits are available for Medically Appropriate and Necessary medical supplies and equipment.

A. Home Medical Equipment

The rental or purchase, at the option of the Claims Administrator of new, used or refurbished Home Medical Equipment, Including wheelchairs, hospital-type beds, infusion pumps and related supplies, crutches and canes when prescribed by a Professional Health Care Provider and Medically Appropriate and Necessary. The rental cost shall not exceed the Allowance of such equipment. No benefits are available for motorized equipment, except wheelchairs when Precertification is received from the Claims Administrator. No benefits are available for batteries required for Home Medical Equipment, except for wheelchair batteries. Covered Services include replacement and repairs when Medically Appropriate and Necessary. Precertification may be required, see Section 3, Authorizations.

Benefits will not be provided for any Home Medical Equipment required for leisure or recreational activity or to allow a Member to participate in a sport activity.

B. Prosthetic Appliances and Limbs

The purchase, fitting and necessary adjustments of Prosthetic Appliances or Limbs and supplies that replace all or part of an absent body part. Benefits are available for standard Prosthetic Appliances and Limbs only. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

Benefits are not available for dental appliances, artificial organs or Prosthetic Appliances and Limbs intended only for cosmetic purposes.

C. Orthotic Devices

Medically Appropriate and Necessary Orthotic Devices when ordered by a Professional Health Care Provider. Guidelines and criteria for Medically Appropriate and Necessary custom molded foot orthotics are available from the Claims Administrator.

Benefits will not be provided for any Orthotic Devices required for leisure or recreational activity or to allow a Member to participate in a sport activity.

D. Supplies for Administration of Prescription Medications or Drugs

Therapeutic devices or appliances related to the administration of Prescription Medications or Drugs in the home, such as hypodermic needles and syringes. See Outpatient Prescription Medications or Drugs for diabetes supplies.

E. Oxygen

Administration of oxygen, Including the rental of equipment.

F. Ostomy Supplies

G. Hearing aids for Members under age 18 subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

## 2.18 EYEGLASSES OR CONTACT LENSES

One pair of eyeglasses or contact lenses if received within 6 months of a covered cataract surgery.

## 2.19 TELEHEALTH

Coverage for Covered Services provided by means of Telehealth is the same as coverage for Covered Services delivered by in-person means.

The standards for Medically Appropriate and Necessary delivery of health care services must be met whether health care services are delivered in-person or via Telehealth.

## 2.20 OUTPATIENT PRESCRIPTION MEDICATIONS OR DRUGS

Benefits are available for Prescription Medications or Drugs approved by the Claims Administrator and that are Medically Appropriate and Necessary for the treatment of a Member and dispensed on or after the effective date of coverage. Benefits include diabetes supplies prescribed by a Health Care Provider.

Prescription Medications or Drugs and diabetes supplies will be categorized by the Claims Administrator as a Formulary Drug, Nonformulary Drug, Nonpayable Drug, Payable Over-the-Counter (OTC) Drug, Restricted Use Drug or Specialty Drug. Restricted Use Drugs require Precertification and/or are subject to a limited dispensing amount or a Step Therapy requirement. Certain Prescription Medications or Drugs are subject to a route of administration exclusion. The coverage for these Prescription Medications or Drugs under this Benefit Plan is available only through medical benefits and not as an Outpatient Prescription Medication or Drug. A list of the various categories of Prescription Medications or Drugs and route of administration exclusions may be obtained by visiting our website at www.BCBSND.com or by calling Member Services. See the telephone number on the back of the Identification Card.

The Claims Administrator utilizes a formulary listing. This listing contains both Brand Name and Generic Prescription Medications or Drugs. If a Member receives a Nonformulary Drug the Nonformulary Drug sanction will apply.

A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication or Drug is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims must be submitted by the Participating Pharmacy. If the Member submits a claim for services received at a Participating Pharmacy, charges in excess of the Allowed Charge are the Subscriber's responsibility.

Note: Specialty Drugs must be received from the preferred specialty pharmacy network.

If a Member receives Prescription Medications or Drugs from a Nonparticipating Pharmacy, the Member is responsible for payment of the Prescription Order or refill in full at the time it is dispensed and to submit appropriate reimbursement information to the Claims Administrator. Payment for covered Prescription Medications or Drugs will be sent to the Subscriber. Any charges in excess of the Allowed Charge are the Subscriber's responsibility.

A Member may call the toll-free number on the Identification Card to obtain information on Pharmacies participating in the Claims Administrator's preferred pharmacy network, preferred mail order pharmacy network and preferred specialty pharmacy network.

## SECTION 3
## AUTHORIZATIONS

This section describes the authorization requirements for specific Covered Services and the Member's responsibilities for these authorizations. The Member's medical care is between the Member and the Member's Health Care Provider. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. The Claims Administrator only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan. The Claims Administrator's decision in this regard shall be final, conclusive and binding upon all parties.**

In an effort to control rising health care costs, the Claims Administrator reserves the option to implement cost management and/or disease management programs. If a cost management and/or disease management program is implemented, the Claims Administrator will establish policies and procedures governing the program.

A Member seeking Covered Services from a Health Care Provider requiring Precertification grants to that Health Care Provider authority to act on behalf of the Member as the Member's Authorized Representative. As an Authorized Representative, the Health Care Provider assumes responsibility to act on behalf of the Member in pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. See Section 6, Claims for Benefits, Appeals and Grievances.

The designation of a Health Care Provider as an Authorized Representative is limited in scope and not an assignment of benefits, nor does it grant the Health Care Provider any of the Member's rights and privileges under the terms of this Benefit Plan.

### 3.1 PRECERTIFICATION PROCESS

This Benefit Plan requires Members to obtain Precertification before benefits are available for specified services, Including:

- air ambulance (non-emergent)
- artificial intervertebral disc
- assisted reproductive technology for GIFT, ZIFT, ICSI and IVF
- autologous chondrocyte implantation
- bariatric surgery
- bone growth stimulator (electrical or ultrasound)
- chimeric antigen receptor (CAR) t-cell therapy
- cochlear implant
- deep brain stimulator
- dental anesthesia and hospitalization for all Members age 9 and older
- electric wheelchairs
- electrical nerve stimulation (phrenic nerve stimulator, implantable peripheral nerve stimulator, occipital nerve stimulation)
- gastric electrical stimulation
- gender reassignment/affirmation surgery
- gene therapy
- Home Health Care
- Hospital bed
- hyperbaric oxygen therapy
- Inpatient Admission to a Rehabilitation Facility
- Inpatient Admissions to a Health Care Provider not participating with the Claims Administrator
- insulin infusion pump, patient owned continuous glucose monitoring systems and artificial pancreas device systems
- intensity-modulated radiotherapy (IMRT)
- limb lengthening
- Long Term Acute Care Facility
- manual wheelchair with accessories

- molecular and genomic testing
- oral appliance for obstructive sleep apnea
- oscillatory devices for respiratory conditions
- osseointegrated dental implants
- percutaneous balloon kyphoplasty, radiofrequency kyphoplasty and mechanical vertebral augmentation
- positron emission tomography (PET) scan
- programmable lymphedema pumps
- Prosthetic Limbs controlled by microprocessors and any Prosthetic Limb replacement within 5 years
- proton beam therapy
- repetitive transcranial magnetic stimulation (rTMS)
- Residential Treatment
- Restricted Use Drugs
- sacral nerve stimulator (trial placement and permanent placement)
- services or procedures which could be considered Cosmetic Services
- Skilled Nursing Facility
- speech generating device
- spinal cord stimulator (trial placement and permanent placement)
- surgical treatment of obstructive sleep apnea
- Targeted Case Management
- Transitional Care Unit
- transplants
- tumor treatment field
- unilateral or bilateral fully or partially implantable bone anchored hearing devices
- vagus nerve stimulator
- wearable cardioverter defibrillators

To request Precertification, the Member or the Member's representative, on the Member's behalf, must notify the Claims Administrator of the Member's intent to receive services requiring Precertification. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary.

A Member seeking Covered Services requiring Precertification designates the Authorized Representative to act and receive notices and information related to a Claim for Benefits on behalf of the Member pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. The Member agrees that all information and notifications related to the Claim for Benefits requiring Precertification is to be directed solely to the Authorized Representative unless the Member specifically requests that any notices or information also be delivered to the Member.

**Receipt of Precertification does not guarantee payment of benefits. All services provided are subject to further review by the Claims Administrator to ensure the services are Medically Appropriate and Necessary. Benefits will be denied if the Member is not eligible for coverage under this Benefit Plan on the date services are provided or if services received are not Medically Appropriate and Necessary as determined by the Claims Administrator in its sole discretion. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan. ALL DETERMINATIONS BY THE CLAIMS ADMINISTRATOR ARE FINAL, CONCLUSIVE AND BINDING UPON ALL PARTIES.**

**Precertification is required prior to obtaining services.**

Admissions for maternity services do not require Precertification.

If the Member's medical condition does not allow the Member to obtain Precertification due to an emergency Admission, the Member or the Member's representative is requested to notify the Claims Administrator of the Admission during the next business day of the Claims Administrator or as soon thereafter as reasonably possible to obtain authorization.

To inquire on the Precertification process, please contact Member Services at the telephone number and address on the back of the Identification Card.

**Notification Responsibility**

If a Member seeks Covered Services from a Health Care Provider that participates with the Claims Administrator, the Participating Health Care Provider assumes responsibility for all Precertification requirements.

If a Member seeks Covered Services from a Health Care Provider that does not participate with the Claims Administrator, compliance with Precertification requirements is the Member's responsibility.

The Claims Administrator will issue a notice of approval or denial following review of the Precertification request.

## 3.2 CONCURRENT REVIEW

Concurrent review is the ongoing review of the Medical Appropriateness and Necessity of the required Admissions outlined in Section 3.1 to an Institutional Health Care Provider. The Claims Administrator will monitor the inpatient Admission to determine whether benefits will be available for continued inpatient care.

If the Claims Administrator in its sole discretion determines benefits are not available because the continued stay is not Medically Appropriate and Necessary, the Claims Administrator will provide notice to the Member, the Member's attending Professional Health Care Provider or the Institutional Health Care Provider. No benefits will be available for services received after the date provided in the Claims Administrator's notice of the termination of benefits.

**Benefits will be denied if the Claims Administrator in its sole discretion determines the services are not Medically Appropriate and Necessary.**

## 3.3 DISCHARGE PLANNING

Discharge planning is the process of assessing the availability of benefits after a hospitalization. The Claims Administrator supports discharge planning by providing information on benefits available for those services determined to be Medically Appropriate and Necessary for the Member's continued care and treatment.

## 3.4 CASE MANAGEMENT

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as:

- admissions that exceed the recommended or approved length of stay;
- utilization of health care services that generates ongoing and/or excessively high costs;
- conditions that are known to require extensive and/or long term follow up care and/or treatment.

The Claims Administrator's case management process may include a flexible benefits option. This option allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the Member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If the Member and the Member's Health Care Provider agree with the plan, alternative benefits will begin immediately and the Member will be asked to sign an alternative benefits agreement that includes the terms listed below, in addition to any other terms specified in the agreement.

Alternative benefits will be made available for a limited period of time and are subject to the Claims Administrator's ongoing review. The Member must cooperate with the review process.

If the Claims Administrator approves alternative benefits, the Claims Administrator does not guarantee that these will be extended beyond the limited time period and/or scope of treatment initially approved or that these will be approved in the future.

The decision to offer alternative benefits is solely the Claims Administrator's and any extension of alternative benefits beyond the specified approved service and/or dates is not subject to the appeals process.

All decisions made by case management are based on the individual circumstances of that Member's case. Each case is reviewed on its own merits and any benefits provided are under individual consideration.

## SECTION 4
## EXCLUSIONS

No benefits are available for services listed in this section. The following list is not a complete list. In addition to these general exclusions, limitations and conditions there may be others that apply to specific Covered Services that can be found in the Covered Services section and elsewhere in this Benefit Plan. If a benefit or service is not covered, then all services, treatments, devices or supplies provided in conjunction with that benefit or service are not covered. Please read this section carefully before seeking services and submitting a Claim for Benefits. Please contact Member Services at the telephone number listed on the back of the Identification Card if you have any questions.

The Claims Administrator shall have full discretion to interpret and determine the application of the Exclusions in each and every situation. Any decisions by the Claims Administrator regarding the Exclusions shall be final, conclusive and binding upon all parties.

### 4.1 EXCLUSIONS

No benefits are available for:

1. Services not prescribed or performed by or under the direct supervision of a Professional Health Care Provider consistent with the Professional Health Care Provider's licensure and scope of practice.

2. Services provided and billed by a registered nurse (other than an Advanced Practice Registered Nurse), intern (professionals in training), licensed athletic trainer or other paramedical personnel.

3. Inpatient Admission services received prior to the effective date of the Member's eligibility under this Benefit Plan.

4. Special education for learning disorders or intellectual disability.

5. Education programs or tutoring services (not specifically defined elsewhere), Including education on self-care, home management or for Medication Therapy Management Services (MTMS) provided outside the pharmacy program.

6. Developmental delay care, Including services or supplies, regardless of where or by whom they are provided, that:

   - Are less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test; or

   - Are educational in nature; vocational and job rehabilitation, recreational therapy; or

   Special education, Including lessons in sign language to instruct a Member whose ability to speak has been lost or impaired to function without that ability.

7. Counseling or therapy services, Including bereavement, codependency, marital dysfunction, family dysfunction, sex or interpersonal relationships.

8. Pharmacological detoxification management, except as specified in Section 2.11.

9. Clinically managed Residential Treatment detoxification, Including social detoxification.

10. Services or treatments for conditions that, according to generally accepted professional standards, are not amenable to favorable modification, except initial evaluation to establish a diagnosis, crisis intervention services and treatment to prevent or halt deterioration or injury or slow the rate of functional loss.

11. Any drug, device, medical service, treatment or procedure that, in the sole discretion of the Claims Administrator, is Experimental or Investigative.

12. Services, treatments or supplies that the Claims Administrator determines in its sole discretion are not Medically Appropriate and Necessary.

13. Transplants, except as specified in this Benefit Plan. Benefits are not available for donor organs or tissue other than human donor organs or tissue.

14. Services that are related to annual, periodic or routine examinations, except as specifically allowed in the Covered Services Section of this Benefit Plan. No benefits are available for physicals, immunizations or screening procedures that are performed solely for school, sports, employment, insurance, licensing, immigration, travel, church or camp.

15. Immunizations, testing or other services required for foreign travel.

16. Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.

17. Room and board at a vocational residential rehabilitation center, a community reentry program, Halfway House or Group Home.

    For the purpose of this exclusion, the following definitions apply:

    Halfway House - a facility for the housing or rehabilitation of persons on probation, parole, or early release from correctional institutions, or other persons found guilty of criminal offenses.

    Group Home - a facility for the housing or rehabilitation of developmentally, mentally or severely disabled persons that does not provide skilled or intermediate nursing care.

18. The surgical or nonsurgical treatment of temporomandibular (TMJ) or craniomandibular (CMJ) joint disorder(s), except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits will be provided for orthodontic services (except as determined Medically Appropriate and Necessary) or osseointegrated dental implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).

19. All contraceptive medications, devices, appliances, supplies and related services when used for contraception, Including contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider. Benefits are available when used for Medically Appropriate and Necessary non-contraception indications.

20. Evaluations and related procedures to evaluate sterilization reversal procedures and the sterilization reversal procedure.

21. Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.

22. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of sperm, embryos or unfertilized eggs, Surrogate pregnancy and delivery, Gestational Carrier pregnancy and delivery, and preimplantation genetic diagnosis testing.

    For the purpose of this exclusion, the following definitions apply:

    Gestational Carrier - an adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.

    Surrogate - an adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.

23. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's physician.

24. Medications obtained without a Prescription Order or for any charges for the administration of legend drugs or insulin that may be Self-Administered unless such administration is Medically Appropriate and Necessary or specifically allowed under this Benefit Plan.

25. Medical treatment and dietary management programs for obesity, except as specifically allowed in the Covered Services Section of this Benefit Plan. Benefits for bariatric surgery are available only when Precertification is obtained from the Claims Administrator. Benefits are subject to a Lifetime Maximum of 1 operative procedure for bariatric surgery per Member.

26. Cosmetic Services. For the purpose of this exclusion the following definition applies:

    Services or procedures with the primary purpose to improve appearance and not primarily to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes, or which primarily improve or alter body features which are variations of normal development.

27. Standby services provided or billed by a Health Care Provider.

28. Alternative treatment therapies, Including acupuncture, acupressure, aquatic whirlpool therapy, chelation therapy, massage therapy, naturopathy, homeopathy, holistic or integrative medicine, hypnotism, hypnotherapy, hypnotic anesthesia, music therapy, equine therapy or therapeutic touch.

29. All forms of thermography for all uses and indications.

30. Testicular prostheses regardless of the cause of the absence of the testicle.

31. Orthotic Devices, Including orthopedic shoes and Home Medical Equipment required for leisure or recreational activities or to allow a Member to participate in sport activities unless Medically Appropriate and Necessary and approved by the Claims Administrator.

32. Palliative or cosmetic foot care, foot support devices (except custom made support devices) or subluxations of the foot, care of corns, bunions (except for capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. Benefits are available for the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with conditions such as circulatory disorders of the legs or feet.

33. Dentistry or dental processes and related charges, Including extraction of teeth, dental appliances Including orthodontia placed in relation to a covered oral surgical procedure, removal of impacted teeth, root canal therapy or procedures relating to the structures supporting the teeth, gingival tissues or alveolar processes, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan.

34. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as specifically allowed in the Schedule of Benefits and Covered Services Sections of this Benefit Plan. No benefits are available for routine vision examinations. No benefits are available for refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses.

35. Hearing aids or examinations for the prescription or fitting of hearing aids. Benefits are available for hearing aids for Members under age 18. No benefits are available for routine hearing examinations. No benefits are available for a tinnitus masker.

36. Services when benefits are provided by any governmental unit or social agency, except for Medicaid or when payment has been made under Medicare Part A or Part B. Medicare Part A and Part B will be considered the primary payor with respect to benefit payments unless otherwise required by federal law.

37. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.

38. Illness or bodily injury that arises out of and in the course of a Member's employment if benefits or compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.

39. Loss caused or contributed by a Member's commission or attempted commission of a felony (except losses caused or contributed by an act of domestic violence or any health condition) or a Member's involvement in an illegal occupation following the Member's enrollment in this Benefit Plan.

40. Any services when benefits are provided by a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, similar person or group.

41. Services provided by a Health Care Provider who is a member of the Member's Immediate Family.

42. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.

    The following methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.

    This exclusion also includes clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.

43. Telephone consultations or charges for failure to keep a scheduled visit or charges for completion of any forms required by the Claims Administrator.

44. Items or services provided primarily for the comfort and convenience of the Member, Including personal hygiene or convenience items, air conditioners, humidifiers, physical fitness equipment or modifications to home or automobile.

45. Repair, replacement or upgrade of Home Medical Equipment if items are damaged, destroyed, lost or stolen due to Member misuse, abuse or carelessness. No benefits are available for replacement or upgrade of Home Medical Equipment when requested for Member convenience or to upgrade to a newer technology when the current components remain functional.

46. Health screening assessment programs or health education services, Including all forms of communication media whether audio, visual or written.

47. Health and athletic club membership or facility use, and all services provided by the facility, Including Physical Therapy, sports medicine therapy and physical exercise.

48. Artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

49. Prosthetic Limbs or components intended only for cosmetic purposes or customized coverings for terminal devices. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a Member to participate in sport activities.

50. Rehabilitative Physical Therapy, Occupational Therapy and Speech Therapy Maintenance Care; work hardening programs; prevocational evaluation; functional capacity evaluations or group speech therapy services.

51. Chiropractic maintenance care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent further problems.

52. Complications resulting from noncovered services received by the Member.

53. Services prescribed by, performed by or under the direct supervision of a Nonpayable Health Care Provider.

54. Services that a Member has no legal obligation to pay in the absence of this or any similar coverage.

55. Cost Sharing Amounts.

56. Services when Precertification was required but not obtained.

57. Brand Name prescription tobacco deterrents if Generic equivalent is available.

58. Low protein modified food products or medical food for maple syrup urine disease or phenylketonuria (PKU), to the extent those benefits are available under a department of health program or other state agency.

59. Food items for medical nutrition therapy, except as specifically allowed in the Covered Services Section of this Benefit Plan.

60. Collection and storage of umbilical cord blood.

61. Services, treatments or supplies not specified as a Covered Service under this Benefit Plan.

## SECTION 5
## GENERAL PROVISIONS

The Claims Administrator shall have full discretion to interpret and determine the application of the General Provisions in each and every situation. Any decisions by the Claims Administrator regarding the General Provisions shall be final, conclusive and binding upon all parties.

### 5.1 STATUS OF MEMBER ELIGIBILITY

The Plan Administrator agrees to furnish the Claims Administrator with any information required by the Claims Administrator for the purpose of enrollment. Any changes affecting a Member's eligibility for coverage must be provided to the Claims Administrator by the Plan Administrator and/or the Member immediately, but in any event the Plan Administrator and/or the Member shall notify the Claims Administrator within 31 days of the change.

Statements made on applications are deemed representations and not warranties. No statements made on the application may be used in any contest unless a copy has been furnished to that person, or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the application at the time of completion.

A Member making a statement (including the omission of information) on the application or in relation to any of the terms of this Benefit Plan constituting fraud or an intentional misrepresentation of a material fact will result in the rescission of this Benefit Plan by the Claims Administrator. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

### 5.2 PHYSICAL EXAMINATIONS

The Claims Administrator at its own expense may require a physical examination of the Member as often as necessary during the pendency of a claim and may require an autopsy in case of death if the autopsy is not prohibited by law.

### 5.3 LIMITATION OF ACTIONS

No legal action may be brought for payment of benefits under this Benefit Plan prior to the expiration of 60 days following the Claims Administrator's receipt of a claim or later than 3 years after the expiration of the time within which notice of a claim is required by this Benefit Plan.

### 5.4 NOTIFICATION REQUIREMENTS AND SPECIAL ENROLLMENT PROVISIONS

A. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any mailing address change within 31 days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any change in marital status within 31 days of the change.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if an application is submitted within 31 days of the date of marriage. If the application is not submitted within the 31-day period, the Eligible Dependent may apply for coverage during the Annual Enrollment Period.

   If the application is submitted within 31 days of the date of marriage, the effective date of coverage for the Eligible Dependents will be the first day of the month following enrollment.

2. If, because of legal separation, divorce, annulment or death, the Subscriber's spouse is no longer eligible for coverage under this Benefit Plan, the Subscriber's spouse must apply within 10 days of legal separation, divorce, annulment or death to be eligible for continuous health coverage. See Section 5.7.

   Coverage for the Subscriber's spouse under Two Person or Family Participation will cease effective the first day of the month immediately following timely notice of legal separation, divorce or annulment.

C. The Subscriber is responsible for notifying the Plan Administrator and the Claims Administrator of any change in family status within 31 days of the change.

The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement or court order. If an application is not submitted within the designated time period, the Eligible Dependent may apply for coverage during the Annual Enrollment Period. The effective date of coverage will be the Group's anniversary date. The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Participation is in force. If the Subscriber is enrolled under another Contract Type, the Subscriber must submit an application for the newborn child within 31 days of the date of birth. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period.

2. Adopted children may be added to this Benefit Plan if an application, accompanied by a copy of the placement agreement or court order, is submitted to the Claims Administrator within 31 days of physical placement of the child. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period.

3. Children for whom the Subscriber or the Subscriber's living, covered spouse have been appointed legal guardian may be added to this Benefit Plan by submitting an application within 31 days of the date legal guardianship is established by court order. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period.

4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting an application within 31 days of the date established by court order. If the application is not submitted within the designated time period, the child may apply for coverage during the Annual Enrollment Period.

5. If any of the Subscriber's children beyond the age of 26 are medically certified as intellectually disabled or physically disabled, the Subscriber may continue their coverage under Parent and Child, Parent and Children or Family Participation. Coverage will remain in effect as long as the child remains disabled, unmarried and financially dependent on the Subscriber or the Subscriber's living, covered spouse. The Claims Administrator may request annual verification of a child's disability after coverage for a disabled child has been in effect for 2 years.

   The Subscriber must provide proof of incapacity and dependency of a child's disability within 31 days after the end of the month in which a child turns 26 or, if a child is beyond age 26, at the time of initial enrollment. If proof of incapacity and dependency for the dependent's disability is not made within 31 days and a lapse in coverage occurs, the child will be required to apply for coverage under a separate benefit plan.

6. If a child is no longer an Eligible Dependent under this Benefit Plan, the child must apply within 10 days of the loss of eligibility to be eligible for continuous health coverage under a separate benefit plan. See Section 5.7.

7. At the time of birth or adoption, Eligible Dependents may be added to this Benefit Plan if an application is submitted to the Claims Administrator within 31 days of birth or physical placement of the adopted child. If the application is not received in accordance with this provision, the Eligible Dependent may apply for coverage during the Annual Enrollment Period.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:

1. During the initial enrollment period the employee or dependent states in writing that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.

2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:

   a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, loss of other coverage triggered by a claim that meets or exceeds a lifetime benefit limitation or the Lifetime Maximum) or employer contributions toward such coverage were terminated; or

   b. was under COBRA and the coverage was exhausted.

3. The employee requests such enrollment within 31 days after the exhaustion or termination of coverage.

The effective date of coverage for an employee and/or dependent who previously declined coverage under this Benefit Plan and is enrolling pursuant to this provision will be the first day immediately following the exhaustion or termination of the employee's and/or dependent's previous coverage. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

If the application is not received in accordance with this provision, the employee or dependent may apply for coverage during the Annual Enrollment Period. The effective date of coverage will be the Group's anniversary date.

E. Employees and/or dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:

1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act and the employee’s or dependent’s coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within 60 days of the date of termination of coverage.

2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within 60 days of the date the employee or dependent is determined to be eligible for premium assistance.

The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

## 5.5 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This provision applies to Members affected by ERISA. See Section 5.8.

This Benefit Plan shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order (QMCSO) pursuant to the provisions of §609 of the Employee Retirement Income Security Act (ERISA) and §1908 of the Social Security Act and any other applicable laws.

The term "child" as used in this provision means any child of a Subscriber who is recognized under a medical child support order as having a right to enrollment under this Benefit Plan with respect to such Subscriber. In connection with any adoption, or placement for adoption, of the child, the term "child" means an individual who has not attained the age of 18 as of the date of such adoption or placement for adoption.

A. A Medical Child Support Order (MCSO) is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

   1. Provides for child support with respect to a child of a Subscriber under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan; or

   2. Enforces a state law relating to medical child support described in §1908 of the Social Security Act with respect to a group health plan.

B. A Qualified Medical Child Support Order is a Medical Child Support Order that:

   1. Creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Subscriber or Member is eligible under the health plan; and

   2. Clearly specifies:

      a. the name and last known mailing address (if any) of the Subscriber and the name and mailing address of each child covered by the order;

      b. a reasonable description of the type of coverage to be provided by the plan to each such child, or the manner in which such type of coverage is to be determined;

      c. the period to which such order applies; and

      d. each plan to which such order applies.

      A MCSO qualifies as a QMCSO only if such order does not require the plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in §1908 of the Social Security Act.

C. The MCSO shall be submitted to the Plan Administrator for review. The Plan Administrator shall determine whether the MCSO qualifies as a QMCSO. The Plan Administrator shall promptly notify the Subscriber and each person specified in a MCSO as eligible to receive benefits under this Benefit Plan, (at the address included in the MCSO) of the receipt of the MCSO and the Plan Administrator's procedures for determining whether the MCSO is a QMCSO. Within 30 days or such other reasonable period after receipt of the MCSO, the Plan Administrator shall determine whether the MCSO is a QMCSO and notify the Subscriber and each child of such determination.

   If the Plan Administrator determines that the MCSO qualifies as a QMCSO, the Plan Administrator shall immediately notify the Claims Administrator of that determination and of the name and mailing address of all children who are to be covered under this Benefit Plan. The Claims Administrator will forward all appropriate forms to each child for enrollment in this Benefit Plan. The forms must be completed by or on behalf of the child and returned to the Claims Administrator.

A child under a QMCSO shall be considered a Member under this Benefit Plan for purposes of any provision of ERISA. A child under any MCSO shall be considered a Subscriber of this Benefit Plan for purposes of the reporting and disclosure requirements of Part I of ERISA. A child may designate a representative for receipt of copies of notices that are sent to the child with respect to a MCSO.

Any payment for benefits made by this Benefit Plan pursuant to a MCSO in reimbursement for expenses paid by a child or a child's custodial parent or legal guardian shall be made to the child or the child's custodial parent or legal guardian.

## 5.6 MEDICAID ELIGIBILITY

This provision applies to Members affected by ERISA. See Section 5.8.

A. When enrolling an individual as a Member, or in determining or making any payment for benefits, this Benefit Plan will not take into account the fact the Member is eligible for or covered by Medicaid.

B. This Benefit Plan will make payment for benefits in accordance with any assignment of rights made by or on behalf of the Member.

C. If Medicaid covers a Member and Medicaid pays benefits that should have been paid by this Benefit Plan, this Benefit Plan will pay those benefits directly to Medicaid rather than to the Member.

## 5.7 CONTINUATION AND CONVERSION

A. Conversion inside the Claims Administrator's Service Area

If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet the Claims Administrator's requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:

1. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion the Plan Administrator through which the Subscriber is eligible has terminated coverage with the Claims Administrator and the Plan Administrator has enrolled with another insurance carrier.

2. The Plan Administrator no longer meets the Claims Administrator's group coverage requirements. The Subscriber will be given the right to convert to the Claims Administrator's nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 10 days after the termination date of the previous benefit plan.

3. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.

4. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under group membership as provided in Section 5.7 (A.)(3.). The Subscriber may elect conversion coverage on a nongroup basis, subject to premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for the Claims Administrator's nongroup coverage within 10 days after the termination date of the previous group health plan coverage.

B. North Dakota Continuation and Conversion

This provision applies to Members not affected by COBRA. See Section 5.7 (C.).

1. If the Subscriber is a member of a group health plan, North Dakota law provides that the Subscriber and the Subscriber's Eligible Dependents, who were continuously covered under this Benefit Plan during a 3-month period immediately preceding termination of membership, may continue coverage under this Benefit Plan. The Subscriber or the Subscriber's Eligible Dependents must request continuation coverage in writing to the Plan Administrator within 10 days after the later of the date of termination or the day the Subscriber is given notice of the right to continuation coverage. Members must elect continuation coverage within 31 days of date of termination.

2. The Subscriber will be responsible for payment of premiums to the Plan Administrator. The initial premium payment must be made within 31 days after the date of termination.

3. Continuation coverage is not available for any person who is covered under Medicare.

4. Continuation coverage will terminate upon the occurrence of one of the following:

   a. The date 39 weeks after the date of termination of the Member's coverage under this Benefit Plan.

   b. Failure to pay premiums as required by the Plan Administrator.

   c. The Plan Administrator terminates this Benefit Plan for all employees of the Group.

5. If an individual is totally disabled on the date coverage is discontinued or replaced, coverage for the totally disabled person will continue upon the individual's payment of premium until the earliest of the following:

   a. The date 12 months after the date of discontinuation of the Group's coverage;

   b. The date the individual is no longer totally disabled; or

   c. The date a succeeding carrier provides replacement coverage to the individual without limitation as to the disabling condition.

6. If because of death, legal separation, divorce, annulment or age, a dependent is no longer eligible for coverage under this Benefit Plan, the dependent may apply to continue or convert coverage.

   a. If the dependent is enrolled through a group health plan and becomes ineligible for coverage due to the death of the Subscriber, continuation and conversion will be provided in accordance with Sections 5.7 (A.)(4.) and (B.)(1.)-(4.).

   b. If the dependent is enrolled through a group health plan and becomes ineligible for coverage due to an annulment of marriage, legal separation or divorce and a court order requires the Subscriber provide continuing coverage, the former spouse and dependent children may continue coverage under the Benefit Plan for a specified period of time, not to exceed 36 months. The former spouse must be covered under a separate benefit plan.

      If the court order does not require the Subscriber to provide continuation coverage for the former spouse and dependent children or upon expiration of the 36-month continuation period, the former spouse and dependent children have the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect. The conversion coverage must provide comparable benefits if an application and premium payment are made within 31 days of notice of termination of the prior coverage. A benefit plan providing reduced benefits at a lesser premium may be elected.

c. If the dependent is enrolled through a group health plan and becomes ineligible because of age, the dependent has the right to convert to a nongroup benefit plan, subject to premium and benefit plan provisions in effect, if an application is submitted within 31 days of the date of ineligibility.

C. Federal Continuation (COBRA)

This provision applies under amendments to the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq. and the Public Health Service Act, 42 U.S.C. §300bb-1, et seq. These amendments are collectively referred to as "COBRA". COBRA provides for optional continuation coverage for certain Subscribers and/or Eligible Dependents under certain circumstances if the employer maintaining the group health plan normally employed 20 or more employees on a typical business day during the preceding calendar year. This provision is intended to comply with the law and any pertinent regulations and its interpretation is governed by them. This provision is not intended to provide any options or coverage beyond what is required by federal law. Subscribers should consult their Plan Administrator to find out if and how this provision applies to them and/or their Eligible Dependents.

A Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if the Subscriber's group coverage is terminated because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct.

The spouse of the Subscriber covered by this Benefit Plan may have the right to choose continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;

2. A termination of the Subscriber's employment for reasons other than gross misconduct or a reduction in hours of employment;

3. Divorce or legal separation; or

4. The Subscriber becomes entitled to Medicare benefits.

A dependent child of the Subscriber covered by this Benefit Plan may have the right to continuation coverage if group coverage is terminated for any of the following reasons:

1. The death of the Subscriber;

2. The termination of the Subscriber's employment for reasons other than gross misconduct or reduction in a parent's hours of employment;

3. Parent's divorce or legal separation;

4. The Subscriber becomes entitled to Medicare; or

5. The dependent ceases to be an Eligible Dependent under this Benefit Plan.

A child who is born to a Subscriber or is placed for adoption with the Subscriber during the period of continuation coverage is eligible for COBRA coverage.

Continuation may apply in the event of a bankruptcy of the Group for certain retired Subscribers and their Eligible Dependents under certain conditions. If there is a bankruptcy of the Group, retired Subscribers and their Eligible Dependents should contact their Plan Administrator for more information.

The Subscriber or the Subscriber's Eligible Dependents have the responsibility to inform the Plan Administrator within 60 days of a divorce, legal separation or a child losing dependent status under this Benefit Plan. Where the Subscriber or an Eligible Dependent have been determined to be disabled under the Social Security Act, they must inform the Plan Administrator of such determination within 60 days after the date of the determination. The Subscriber or the Subscriber's Eligible Dependents are responsible for notifying the Plan Administrator within 30 days after the date of any final determination under the Social Security Act that the Subscriber or Eligible Dependent is no longer disabled.

When the Plan Administrator is notified that one of these events has occurred or has knowledge of the Subscriber's death, termination of employment, reduction in hours or Medicare entitlement, the Plan Administrator will notify the Subscriber or Eligible Dependents, as required by law of the right to choose continuation coverage. The Subscriber or Eligible Dependents has 60 days from the date coverage is lost, because of one of the events described above or 60 days from the date the Subscriber or Eligible Dependent is sent notice of his or her right to choose continuation coverage, whichever is later, to inform the Plan Administrator of the decision to continue coverage. If the Subscriber or Eligible Dependent does not choose continuation coverage, group coverage will terminate.

If the Subscriber chooses continuation coverage, the Plan Administrator is required to provide coverage identical to the coverage provided under the plan to similarly situated employees or family members. If group coverage is lost because of a termination of employment or reduction in hours, the Subscriber and Eligible Dependents may maintain continuation of coverage for 18 months. The law requires Eligible Dependents be given the opportunity to maintain continuation of coverage for 36 months in the event of the Subscriber's death, divorce, legal separation, or Medicare entitlement, or a child's loss of dependent status.

An 18-month extension of coverage is available to Eligible Dependents who elect continuation coverage if a second event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second event occurs is 36 months. A second event includes loss of dependency status. A second event occurs only if it causes an Eligible Dependent to lose coverage under the Plan as if the first event had not occurred. Eligible Dependents must notify the Plan Administrator within 60 days after the second event occurs. If group coverage is lost because of a termination of employment or reduction in hours and the Subscriber becomes entitled to Medicare benefits less than 18 months before the termination or reduction in hours, Eligible Dependents may maintain continuation coverage for up to 36 months after the date of Medicare entitlement.

A Subscriber or Eligible Dependent determined to have been disabled for Social Security purposes at the time of termination of employment or reduction in hours or who becomes disabled at any time during the first 60 days of COBRA continuation coverage and who provides notice of such determination to the Plan Administrator, may be entitled to receive up to an additional 11 months of continuation coverage, for a total maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. If the individual entitled to the disability extension has nondisabled family members who are entitled to continuation coverage, those nondisabled family members also may be entitled to extend the continuation coverage to 29 months.

There is a second 60-day election period for certain individuals who lose group health coverage and are eligible for federal trade adjustment assistance. The second election period applies only to those individuals who did not elect continuation coverage under the initial 60-day election period and who meet federal trade adjustment assistance eligibility guidelines. The second 60-day election period begins on the first day of the month in which the individual is determined to be eligible for trade adjustment assistance, but in no event may elections be made later than 6 months after the loss of group coverage. If elected, continuation coverage will be measured from the date of loss of group coverage.

Notwithstanding the availability of continuation coverage, the law also provides that continuation coverage may be terminated for any of the following reasons:

1. The Group no longer provides group coverage to any of its employees;

2. Failure to make the premium payment;

3. The person receiving continuation coverage becomes covered under another benefit plan providing the same or similar coverage (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition of such person; (for plan years beginning on or after July 1, 1997, or later for certain plans maintained pursuant to one or more collective bargaining agreements, if the other benefit plan limits or excludes benefits for preexisting conditions but because of new rules applicable under the Health Insurance Portability and Accountability Act of 1996 those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage under this benefit plan, then this benefit plan can stop making the COBRA continuation coverage available to the individual); or

4. Entitlement to Medicare benefits.

Under the law a Subscriber may have to pay all or part of the premium for continuation coverage.

## 5.8 ERISA RIGHTS

As a Subscriber of this Benefit Plan enrolled through a group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Subscribers shall be entitled to:

A. Receive Information About Your Plan and Benefits.

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

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

3. Receive a summary of the annual financial report of the Benefit Plan. The Plan Administrator is required by law to furnish each Subscriber with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Benefit Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review your summary plan description and the document governing the Benefit Plan on the rules governing your COBRA continuation coverage rights.

C. Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Subscribers, ERISA imposes duties upon the people who are responsible for the operation of the Benefit Plan. The people who operate the Benefit Plan, called "fiduciaries" of the Benefit Plan, have a duty to do so prudently and in the interest of the Members. No one, including the employer, union, or any other person, may fire or otherwise discriminate against the Subscriber in any way to prevent them from obtaining a benefit or exercising rights under ERISA.

D. Enforce Your Rights.

If a Claim for Benefits is denied or ignored, in whole or in part, the Subscriber has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

E. Assistance with Your Questions.

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

## 5.9 AMENDMENT OF BENEFIT PLAN

The terms of this Benefit Plan may be amended at any time by the Plan Administrator. However, any liability of the Claims Administrator under the stop-loss portion of this Benefit Plan shall be limited to the terms of the benefit plan document as written and approved by the Plan Administrator and the Claims Administrator regardless of whether any court determines that the terms of this Benefit Plan or any amendments thereof are invalid with respect to the Plan Administrator. The Claims Administrator shall not incur any liability for benefits, expenses or other payments under this Benefit Plan as a result of any amendment of this Benefit Plan nor shall any such amendment be considered in determining the stop-loss attachment point/coverage unless and until the Claims Administrator is notified in writing by certified mail of the amendment and the President and Chief Executive Officer of the Claims Administrator has agreed to the amendment in writing and the stop-loss coverage is modified accordingly. The Plan Administrator will furnish a summary description to each Member who is receiving benefits under the Benefit Plan in accordance with ERISA §104 and applicable regulations. The Claims Administrator is not responsible for notifying Members of any amendments nor is the Claims Administrator responsible for any other duties assigned to the Plan Administrator by ERISA or the terms of this Benefit Plan.

## 5.10 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

If the Benefit Plan is terminated, modified or amended, coverage is automatically terminated, modified or amended for all enrolled Members of the group health plan. It is the Plan Administrator's responsibility to notify Members of the termination of coverage.

## 5.11 NOTICE TO MOTHERS AND NEWBORNS

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Health Care Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## 5.12 MEMBER - PROVIDER RELATIONSHIP

Benefits are available only for Medically Appropriate and Necessary services while under the care and treatment of a Health Care Provider. Nothing herein contained shall interfere with the professional relationship between the Member and his or her Health Care Provider.

If the Member remains in an institution after advice is received from the attending Physician that further hospitalization is unnecessary, the Subscriber shall be solely responsible to the institution for all charges incurred after he or she has been so advised. Further, the Claims Administrator may at any time request the attending Physician to certify the necessity of further confinement. If the attending Physician does not certify that further confinement is necessary, the Member is not entitled to further benefits during the confinement.

Each Member is free to select a Health Care Provider and discharge such Health Care Provider. Health Care Providers are free to provide medical care according to his or her own judgment. Nothing contained in this Benefit Plan will interfere with the ordinary relationship that exists between a Health Care Provider and patient or obligate the Claims Administrator in any circumstances to supply a Health Care Provider for any Member. The provision of medical care and/or the decision not to provide medical care may have a financial impact on the Health Care Provider. The Member should consult with his/her Health Care Provider regarding the nature and extent of such a financial impact, if any, as well as how it might affect medical care decisions.

A Member's medical care is between the Member and the Member's Health Care Provider, and this Benefit Plan only explains what is or is not covered, not what medical care the Member should seek.

Costs relating to any services subject to the authorization provisions that are not approved by the Claims Administrator will not be covered. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. The Claims Administrator only has the authority and discretion to determine the extent of benefits available for Covered Services under this Benefit Plan.**

The Member agrees to conform to the rules and regulations of the Hospital in which he or she is a patient, including those rules governing Admissions and types and scope of services furnished by said Hospital.

## 5.13 CLAIMS ADMINISTRATOR'S RIGHT TO RECOVERY OF PAYMENT

All Members expressly consent and agree to reimburse the Claims Administrator for benefits provided or paid for which a Member was not eligible under the terms of this Benefit Plan. Such reimbursement shall be due and payable immediately upon notification and demand by the Claims Administrator. Further, at the option of the Claims Administrator, benefits or the Allowance therefore may be diminished or reduced as an off set toward such reimbursement. Acceptance of membership fees, or providing or paying benefits by the Claims Administrator, shall not constitute a waiver of their rights to enforce these provisions in the future.

## 5.14 CONFIDENTIALITY

All Protected Health Information (PHI) maintained by the Claims Administrator under this Benefit Plan is confidential. Any PHI about a Member under this Benefit Plan obtained by the Claims Administrator from that Member or from a Health Care Provider may not be disclosed to any person except:

A. Upon a written, dated, and signed authorization by the Member or prospective Member or by a person authorized to provide consent for a minor or an incapacitated person;

B. If PHI identifies the Health Care Provider, upon a written, dated, and signed approval by the Health Care Provider. However, the Claims Administrator may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. The Claims Administrator may also disclose to a Health Care Provider, as part of a contract or agreement in which the Health Care Provider is a party, data or information that identifies a Health Care Provider as part of mutually agreed upon terms and conditions of the contract or agreement;

C. If the data or information does not identify either the Member or prospective Member or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;

D. Pursuant to statute or court order for the production or discovery of evidence; or

E. In the event of a claim or litigation between the Member or prospective Member and the Claims Administrator in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for the Claims Administrator to conduct health care operations, Including utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with Health Care Providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to PHI disclosed by the Claims Administrator as part of a research project approved by an institutional review board established under federal law. This section does not apply to PHI disclosed by the Claims Administrator to the insurance commissioner for access to records of the Claims Administrator for purposes of enforcement or other activities related to compliance with state or federal laws.

## 5.15 PRIVACY OF PROTECTED HEALTH INFORMATION

The Claims Administrator will not disclose the Member's Protected Health Information (PHI) to the Group unless the Group certifies that the Benefit Plan has been amended to incorporate the privacy restrictions required under federal and state law, and agrees to abide by them.

The Claims Administrator will disclose the Member's PHI to the Group to carry out administrative functions under the terms of the Benefit Plan, but only in accordance with applicable federal and state law. Any disclosure to and use by the Group of the Member's PHI will be subject to and consistent with this section. The Claims Administrator will not disclose the Member's PHI to the Group unless such disclosures are included in a notice of privacy practices distributed to the Member. The Claims Administrator will not disclose the Member's PHI to the Group for actions or decisions related to the Member's employment or in connection with any other benefits made available to the Member.

The following restricts the Group's use and disclosure of the Member's PHI:

A. The Group will neither use nor further disclose the Member's PHI except as permitted by the Benefit Plan or required by law.

B. The Group will ensure that anyone who receives the Member's PHI agrees to the restrictions and conditions of the Benefit Plan with respect to the Member's PHI.

C. The Group will not use or disclose the Member's PHI for actions or decisions related to the Member's employment or in connection with any other benefit made available to the Member.

D. The Group will promptly report to the Plan Administrator any use or disclosure of the Member's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.

E. In accordance with federal law, the Group will make PHI available to the Member who is the subject of the information. Such information is subject to amendment and, upon proper notice, the Group will amend the Member's PHI where appropriate.

F. The Group will document disclosures it makes of the Member's PHI so the Plan Administrator is able to provide an accounting of disclosures as required under applicable state and federal law.

G. The Group will make its internal practices, books, and records relating to its use and disclosure of the Member's PHI available to the Plan Administrator and to the U.S. Department of Health and Human Services as necessary to determine compliance with federal law.

H. The Group will, where feasible, return or destroy all Members PHI in whatever form or medium received from the Plan Administrator, including all copies of and any data or compilations derived from and allowing identification of any Member when the Member's PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Group will limit the use or disclosure of any Member PHI to those purposes that make the return or destruction of the information infeasible.

## 5.16 NOTICE OF PRIVACY PRACTICES

The Claims Administrator maintains a Notice of Privacy Practices. This Notice of Privacy Practices outlines the Claims Administrator's uses and disclosures of PHI, sets forth the Claims Administrator's legal duties with respect to PHI and describes a Member's rights with respect to PHI. Members can obtain a Notice of Privacy Practices by contacting Member Services at the telephone number and address on the back of the Identification Card or by visiting the Claims Administrator's website.

## 5.17 SECURITY MEASURES FOR ELECTRONIC PROTECTED HEALTH INFORMATION

A. The Group will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Members' electronic PHI that the Group creates, receives, maintains, or transmits on the Plan Administrator's behalf.

B. The Group will report to the Plan Administrator any attempted or successful (1) unauthorized access, use, disclosure, modification, or destruction of Members' electronic PHI or (2) interference with the Group's system operations in the Group's information systems, of which the Group becomes aware, except any such security incident that results in disclosure of Members' PHI not permitted by the Benefit Plan must be reported to the Plan Administrator as required by 5.15 (D).

C. The Group will support the adequate separation between the Group and the Plan Administrator, as specified in the Benefit Plan, with reasonable and appropriate security measures.

## 5.18 RETROSPECTIVE DISCOUNT PAYMENT DISCLOSURE

A Member may be required to pay Cost Sharing Amounts for each Prescription Medication or Drug provided under the terms of this Benefit Plan. A Member will pay these Cost Sharing Amounts directly to the Health Care Provider at the time the Prescription Medication or Drug is dispensed or administered.

In some cases, drug manufacturers may offer retrospective discount payments on certain specific Prescription Medications and Drugs dispensed or administered to Members under the terms of this Benefit Plan. Such retrospective discount payments from the manufacturer are not determined or paid by the manufacturer until at least one year following the date a Prescription Medication or Drug was provided to a Member under the terms of this Benefit Plan. A portion of these retrospective discount payments, if offered, is retained by an entity that performs pharmaceutical manufacturer discount program services through a contract with the Claims Administrator on behalf of this Benefit Plan. Another portion of these retrospective discount payments, if offered, is paid to the Claims Administrator.

Pharmaceutical manufacturer discount program services Include the following: processing and handling of pharmaceutical manufacturer retrospective discounts for applicable claims; billing and collecting appropriate retrospective discounts on those claims from manufacturers; distributing payments in accordance with the terms of manufacturer discount program service agreements; formulary development, use and communication; benefit design analysis and consultation; annual analysis of claims data and recommendations; monthly utilization reporting; formulary appeals; and clinical services including physician and disease-state education programs.

## SECTION 6
## CLAIMS FOR BENEFITS, APPEALS AND GRIEVANCES

The Claims Administrator shall have full discretion to interpret and determine the application of Claims for Benefits and Appeals in each and every situation. Any decisions by the Claims Administrator regarding Claims for Benefits and Appeals shall be final, conclusive and binding upon all parties.

A Member may submit a Claim for Benefits by contacting the Claims Administrator at the telephone number or address listed on the back of the Identification Card. The Member is responsible for providing the Claims Administrator with a Claim for Benefits within 18 months after the date the benefits or services offered under this Benefit Plan were incurred. A Claim for Benefits must include the information necessary for the Claims Administrator to determine benefits or services.

The Member may designate an Authorized Representative to pursue a Claim for Benefits or appeal an adverse determination from a Claim for Benefits. The designation of an Authorized Representative is limited in scope and not an assignment of benefits. It does not grant the Authorized Representative any of the Member's rights and privileges under the terms of this Benefit Plan. See Section 3, Authorizations.

Upon receipt of a Claim for Benefits under this Benefit Plan from a Member and/or the Member's Authorized Representative, the following claims review and appeals process applies:

**Maximum Time Limits for Claim for Benefits Processing**

| Type of Notice | Emergency Claim for Benefits | Pre-Service Claim for Benefits | Post-Service Claim for Benefits | Ongoing Course of Treatment Claim for Benefits |
|---|---|---|---|---|
| Initial Determinations (Plan)<br>Extensions | 72 Hours<br>NONE | 15 Days<br>15 Days | 30 Days<br>15 Days | Notification "sufficiently in advance" of reduction or termination of benefits.* |
| Improperly Filed Claims (Plan) | 24 Hours | 5 Days | NONE | N/A |
| Additional Information Request (Plan) | 24 Hours | 15 Days | 30 Days | N/A |
| Response to Request For Additional Information (Claimant) | 48 Hours | 45 Days | 45 Days | N/A |
| Request for Appeal (Claimant) | 180 Days | 180 Days | 180 Days | N/A |
| Appeal Determinations (Plan)<br>Extensions | 72 Hours<br>NONE | 30 Days<br>NONE | 60 Days<br>NONE | As appropriate to the type of Claim for Benefits. |

*If Claim for Benefits is made at least 24 hours before expiration of treatment and the Claim for Benefits involves an urgent care Claim for Benefits, the Claims Administrator's decision must be made within 24 hours of receipt of the Claim for Benefits.

## 6.1 CLAIMS FOR BENEFITS INVOLVING PRECERTIFICATION (PRESERVICE CLAIMS FOR BENEFITS)

A. Claims for Benefits Requiring Precertification.

1. Claims for Benefits Requiring Precertification. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative that is conditioned on a Member obtaining approval in advance of obtaining the benefit or service, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days from receiving the Claim for Benefits. The Claims Administrator may extend this initial time period an additional 15 days if the Claims Administrator is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 15-day time period.

   If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits, the Claims Administrator will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 5 days after receipt of the Claim for Benefits and provide the Member and/or the Member's Authorized Representative with the proper procedures to be followed when filing a Claim for Benefits. The Claims Administrator may also request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 15-day time period after receiving the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to properly file the Claim for Benefits and submit the requested information. After receiving the properly filed Claim for Benefits or additional or specified information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 15 days after receipt of the properly filed Claim for Benefits and additional information.

2. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, the Claims Administrator will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

3. Appeals of Claims for Benefits Requiring Precertification. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits requiring Precertification of benefits or services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

B. Claims for Benefits Involving Emergency Care or Treatment

1. Claims for Benefits for Emergency Services. Upon receipt of a Claim for Benefits for Emergency Services from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 72 hours after receiving the Claim for Benefits.

If the Member and/or the Member's Authorized Representative improperly submits a Claim for Benefits or the Claim for Benefits is incomplete and the Claims Administrator requests additional or specified information, the Claims Administrator will notify the Member and/or the Member's Authorized Representative as soon as possible but no later than 24 hours after receipt of the Claim for Benefits. Upon receiving notice of an improperly filed Claim for Benefits or the request from the Claims Administrator for additional or specified information, the Member and/or the Member's Authorized Representative has 48 hours to properly file the Claim for Benefits or to provide the requested information. After receiving the properly filed Claim for Benefits or requested information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination as soon as possible but no later than 48 hours after receipt of the additional or specified information requested by the Claims Administrator or within 48 hours after expiration of the Member's time period to respond.

2. Appeals of Claims for Benefits for Emergency Services. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits for Emergency Services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination, whether adverse or not, as soon as possible but no later than 72 hours after receiving the Member's and/or the Member's Authorized Representative's request for review. A Member and/or a Member's Authorized Representative may request an appeal from a determination involving a Claim for Benefits for Emergency Services orally or in writing, and the Claims Administrator will accept needed materials by telephone or facsimile.

## 6.2 ALL OTHER CLAIMS FOR BENEFITS (POST SERVICE CLAIM FOR BENEFITS)

A. Claims for Benefits for All Other Services or Benefits. Upon receipt of a Claim for Benefits under the Benefit Plan from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days from receiving the Claim for Benefits and only if the determination is adverse to the Member. The Claims Administrator may extend this initial time period in reviewing a Claim for Benefits an additional 15 days if the Claims Administrator is unable to make a determination due to circumstances beyond its control after giving the Member and/or the Member's Authorized Representative notice of the need for additional time prior to the expiration of the initial 30-day time period.

The Claims Administrator may request additional or specified information after receiving a Claim for Benefits, but any such request will be made prior to the expiration of the initial 30-day time period after receiving the Claim for Benefits. Upon receiving a request for additional or specified information, the Member and/or the Member's Authorized Representative has 45 days in which to submit the requested information. After receiving the additional or specified information, the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 30 days after receipt of the additional information.

B. Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments. For a Claim for Benefits involving services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, the Claims Administrator will provide the Member and/or the Member's Authorized Representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Member and/or the Member's Authorized Representative to request extending the course of treatment or number of treatments. Upon receiving a Claim for Benefits from a Member and/or a Member's Authorized Representative to extend such treatment, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

C. Appeals from Initial Claims for Benefits Determinations for All Other Claims for Services or Benefits. The Member and/or the Member's Authorized Representative have up to 180 days to appeal the Claims Administrator's benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, the Claims Administrator will notify the Member and/or the Member's Authorized Representative of its determination within a reasonable period of time but no later than 60 days after receiving the Member's and/or the Member's Authorized Representative's request for review.

**Maximum Time Limits for Processing External Review (External Appeals)**

| Type of Notice | External Review (Standard) | External Review (Expedited) |
|---|---|---|
| Request for Review (Claimant) | The first business day of the 5th month following receipt of an adverse determination from Plan. | The first business day of the 5th month following receipt of an adverse determination from Plan. |
| Preliminary Review (Plan) | 5 Business Days | Immediately |
| Incomplete Review Submission (Plan) | 1 Business Day | Immediately |
| Response to Incomplete Review Submission (Claimant) | The first business day of the 5th month following receipt of an adverse determination from Plan or 48 hours, whichever is later. | The first business day of the 5th month following receipt of an adverse determination from Plan or 48 hours, whichever is later. |
| Ineligible Review Determination (Plan) | 1 Business Day | Immediately |
| Eligible Review Determination (Plan) | 1 Business Day | Immediately |
| Referral of Review to Independent Review Organization (IRO) (Plan) | Must submit appeal documents to IRO within 5 business days | Immediately |
| Notice of Final Review Determination (IRO) | Within 45 days following receipt of request for external review | Expeditiously but no more than 72 hours following written request and within 48 hours if the notice is not in writing. |

## 6.3 EXTERNAL REVIEW PROCESS OF CLAIMS FOR BENEFITS (EXTERNAL APPEALS) - PROTECTIONS FROM CERTAIN EXCESS CHARGES

A. External Review of Claims for Benefits (Standard)

1. Request for External Review. Under certain circumstances following utilization of the Claims Administrator's internal Claims for Benefits and Appeals process (Section 6.1 and/or 6.2), a Member and/or a Member's Authorized Representative may request an external review by submitting a request to the Claims Administrator. A request for external review is available only for determinations by the Claims Administrator that are adverse to the Member and based on the Claims Administrator's administration of the excess change protections as outlined in Section 1.3, Selecting a Health Care Provider. This request for external review must be submitted by the first business day of the 5th month following the Claims Administrator's final determination pursuant to the internal Claims for Benefits and Appeals process.

A Member and/or a Member's Authorized Representative must adhere to the Claims Administrator's internal Claims for Benefits and Appeals process (Section 6.1 and/or 6.2) before requesting an external review under this provision unless the Claims Administrator waives this requirement, the Claims Administrator fails to comply with its internal Claims for Benefits and Appeals process (Section 6.1 and/or 6.2) and this noncompliance causes, or is likely to cause, prejudice or harm to the Member, or the Member and/or a Member's Authorized Representative requests an expedited internal Claims for Benefits and Appeals review and an external Claims for Benefits and Appeals review at the same time.

In pursuing any external review under this provision, no costs will be incurred by the Member.

2. Preliminary Review by the Claims Administrator. Within 5 business days following receipt of a Member's and/or a Member's Authorized Representative's request for external review, the Claims Administrator must complete a preliminary review of the request. This preliminary review is used to determine whether the claimant is or was eligible for coverage under this Benefit Plan at the time the service or procedure was requested, the Member and/or a Member's Authorized Representative has completed the applicable internal Claims for Benefits and Appeals requirements set forth in Section 6.1 and/or 6.2 of this Benefit Plan, and the Member and/or the Member's Authorized Representative has submitted all information necessary to process the external review. If the request for external review is incomplete, within 1 business day the Claims Administrator must provide notice to the Member and/or the Member's Authorized Representative describing the information and other materials needed to complete the request. The Member and/or the Member's Authorized Representative must submit the information described in the notice provided by the Claims Administrator by the first business day of the 5th month following the Claims Administrator's final determination pursuant to the internal Claims for Benefits and Appeals process or within 48 hours following receipt of this notice from the Claims Administrator, whichever is later.

    a. If the request for external review submitted by the Member and/or the Member's Authorized Representative is complete but the Member is not eligible for the external review process, within 1 business day of making its determination that the Member is not eligible for the external review process, the Claims Administrator shall provide notification of this fact to the Member and/or the Member's Authorized Representative, including the reasons for the Member's ineligibility. If the Member and/or the Member's Authorized Representative has any questions in regard to this determination by the Claims Administrator, the Member and/or the Member's Authorized Representative may contact the Employee Benefits Security Administration toll-free at 866-444-3272.

    b. If the request for external review submitted by the Member and/or the Member's Authorized Representative is complete and meets the eligibility requirements for external review, within 1 business day the Claims Administrator shall notify the Member and/or the Member's Authorized Representative of this fact and assign the Member's and/or the Member's Authorized Representative's request for external review to an independent review organization (IRO).

3. Referral of External Review to Independent Review Organization (IRO). Upon receiving the assignment of the Member's and/or the Member's Authorized Representative's request for external review, the following process shall be implemented.

    a. The Claims Administrator shall assign a Member's request for external review to an IRO under contract with the Claims Administrator on a random, rotating basis and pursuant to its policy eliminating conflicts of interest to the IRO that may influence its determination.

b. The assigned IRO shall notify the Member and/or the Member's Authorized Representative in a timely manner and in writing of the assignment of the Member's and/or the Member's Authorized Representative's request for external review by the Claims Administrator to the IRO. The IRO shall notify the Member and/or the Member's Authorized Representative that the Member and/or the Member's Authorized Representative has up to 10 business days following this written notice to submit any additional information the Member and/or the Member's Authorized Representative wants the IRO to consider when completing the external review.

c. Within 5 business days after the date that the Claims Administrator assigns the Member's and/or the Member's Authorized Representative's request for external review to an IRO, the Claims Administrator shall provide the assigned IRO the documents and any information considered in the Claims for Benefits determination completed by the Claims Administrator.

d. Should the Member and/or the Member's Authorized Representative submit additional information to the IRO as a result of the written notification provided by the IRO to the Member and/or the Member's Authorized Representative, the IRO must forward this information to the Claims Administrator within 1 business day. Upon receipt of this information, in its discretion, the Claims Administrator may reconsider its initial Claims for Benefits determination that is the subject of the request for external review and determine to reverse its initial determination. Upon any review completed under these circumstances, the Claims Administrator must notify the IRO and the Member and/or the Member's Authorized Representative of its determination and the IRO must terminate the external review assigned by the Claims Administrator.

e. The IRO shall review all of the information and documents submitted to it in a timely manner in completing its external review. The assigned IRO shall complete its review and provide notice of its final determination to the Member and/or the Member's Authorized Representative and the Claims Administrator within 45 days after the IRO receives its assignment of the request for external review. The determination of the IRO is final and binding on the Member and the Claims Administrator, subject to any other remedies available under state or federal law.

B. External Review of Claims for Benefits (Expedited)

1. Request for Expedited External Review. Under certain circumstances a Member and/or a Member's Authorized Representative may request an expedited external review by submitting a request to the Claims Administrator. A request for expedited external review is available only for determinations by the Claims Administrator that are adverse to the Member and based on the Claims Administrator's administration of the excess charge protections as outlined in Section 1.3, Selecting a Health Care Provider. At the time the Member and/or the Member's Authorized Representative makes a request for expedited external review, the internal Claims for Benefits determination completed by the Claims Administrator must involve a medical condition of the Member where the timeframe for completing a standard internal appeal would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and the Member and/or the Member's Authorized Representative submitted a request for an expedited internal appeal with the Claims Administrator, or the internal Claims for Benefits determination completed upon appeal by the Claims Administrator involves a Member's medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Member, would jeopardize the Member's ability to regain maximum function, or if the internal Claims for Benefits determination completed upon appeal by the Claims Administrator involves an admission, availability of care, continued stay, or health care item or service for which the Member received Emergency Services but has not been discharged from a health care facility. This request for expedited external review must be submitted by the first business day of the 5th month following the Claims Administrator's final determination pursuant to the internal Claims for Benefits and Appeals process.

A Member and/or a Member's Authorized Representative must adhere to the Claims Administrator's internal Claims for Benefits and Appeals process (Section 6.1 and/or 6.2) before requesting an external review under this provision unless the Claims Administrator waives this requirement, the Claims Administrator fails to comply with its internal Claims for Benefits and Appeals process (Section 6.1 and/or 6.2) and this noncompliance causes, or is likely to cause, prejudice or harm to the Member, or the Member and/or the Member's Authorized Representative requests an expedited internal appeal and an external review at the same time.

In pursuing any external review under this provision, no costs will be incurred by the Member.

2. Preliminary Review by the Claims Administrator. Immediately following receipt of a Member's and/or the Member's Authorized Representative's request for expedited external review, the Claims Administrator must complete a preliminary review of the request. This preliminary review is used to determine whether the claimant is or was eligible for coverage under this Benefit Plan at the time the service or procedure was requested, the Member and/or the Member's Authorized Representative has completed the applicable internal Claims for Benefits and Appeals as requested, and the Member and/or the Member's Authorized Representative has submitted all information necessary to process the expedited external review. If the Member's and/or the Member's Authorized Representative's request for expedited external review is incomplete, the Claims Administrator must immediately provide notice to the Member and/or the Member's Authorized Representative describing the information and other materials needed to complete the request. The Member and/or the Member's Authorized Representative must submit the information described in the notice provided by the Claims Administrator by the first business day of the 5th month following the Claims Administrator's final determination pursuant to the internal Claims for Benefits and Appeals process or within 48 hours following receipt of this notice from the Claims Administrator, whichever is later.

   a. If the request for expedited external review submitted by the Member and/or the Member's Authorized Representative is complete but the Member is not eligible for the expedited external review process, immediately after making its determination that the Member is not eligible for the expedited external review process, the Claims Administrator shall provide notification of this fact to the Member and/or the Member's Authorized Representative, including the reasons for the Member's ineligibility. If the Member and/or the Member's Authorized Representative have any questions in regard to this determination by the Claims Administrator, the Member and/or the Member's Authorized Representative may contact the Employee Benefits Security Administration toll-free at 866-444-3272.

   b. If the request for expedited external review submitted by the Member and/or the Member's Authorized Representative is complete and meets the eligibility requirements for expedited external review, the Claims Administrator shall immediately notify the Member and/or the Member's Authorized Representative of this fact and assign the Member's and/or the Member's Authorized Representative's request for expedited external review to an independent review organization (IRO).

3. Referral of Expedited External Review to Independent Review Organization (IRO). Upon receiving the assignment of the Member's and/or the Member's Authorized Representative's request for expedited external review, the following process shall be implemented.

   a. The Claims Administrator shall assign a Member's request for external review to an IRO under contract with the Claims Administrator on a random, rotating basis and pursuant to its policy eliminating conflicts of interest to the IRO that may influence its determination.

   b. After the Claims Administrator assigns a Member's and/or the Member's Authorized Representative's request for expedited external review to an IRO, the Claims Administrator shall provide or transmit to the assigned IRO electronically, by telephone, facsimile or any other expeditious method available all necessary documents and any information considered in the internal Claims for Benefits determination completed by the Claims Administrator.

c. The IRO shall review all of the information and documents submitted to it in a timely manner in completing its expedited external review. The assigned IRO shall complete its review and provide notice of its final determination to the Member and/or the Member's Authorized Representative and the Claims Administrator as expeditiously as the Member's medical condition or circumstance require, but in no event more than 72 hours after the IRO receives the request for expedited external review from the Claims Administrator and, if this notice is not in writing, written confirmation of the determination within 48 hours after the IRO receives its assignment of the request for expedited external review. The determination of the IRO is final and binding on the Member and the Claims Administrator, subject to any other remedies available under state or federal law.

To inquire on the Claims for Benefits and Appeals process, please contact Member Services at the telephone number and address on the back of the Identification Card.

## 6.4 GRIEVANCES

In certain situations, a Member and/or the Member's Authorized Representative may file a grievance with the Claims Administrator. A "grievance" is a written or oral complaint, if the complaint is submitted by or on behalf of a Member and/or the Member's Authorized Representative, that involves one of the following:

A. Quality of Care Grievance - a complaint related to the quality of health care services provided by a Health Care Provider;

B. Quality of Service Grievance - a complaint related to the non-clinical services received by a Member that may include but are not limited to complaints regarding access to care, waiting times, claims payment or reimbursement for health care services; or

C. Administrative Grievance - any complaint involving the terms of coverage and plan services administered by the Claims Administrator.

The Member and/or the Member's Authorized Representative can file a grievance or receive assistance with filing and/or completing a grievance by contacting Member Services at Blue Cross Blue Shield of North Dakota, PO Box 1570, Fargo, North Dakota 58107-1570 or telephone 1-844-363-8457.

Grievances may be filed orally or in writing no later than 180 days after the incident. The Member and/or the Member's Authorized Representative will receive a response within 30 days.

## SECTION 7
## OTHER PARTY LIABILITY

This section describes the Claims Administrator's Other Party Liability programs and coordinating benefits and services when a Member has other health care coverage available, and outlines the Member's responsibilities under these programs. The Claims Administrator shall determine the interpretation and application of the following Other Party Liability provisions in each and every situation.

### 7.1 COORDINATION OF BENEFITS

This provision applies when a Member is enrolled under another plan (defined below), whether insured or self-funded, with a similar coordination of benefits provision. If the sum of benefits payable under this Benefit Plan and the other plan exceed the total allowable expense for Covered Services, the benefits payable under this Benefit Plan will be reduced so the sum of benefits payable under all plans does not exceed 100% of the total allowable expense for Covered Services.

For the purposes of this coordination of benefits provision, the following definitions apply:

"Allowable expense" means a health care expense, including deductibles, coinsurance and copayments (if required as part of a plan), that is covered at least in part by any plan covering a Member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense not covered by any plan covering a Member is not an allowable expense. In addition, any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a Member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a Member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Closed panel plan" means a plan that provides health care benefits to Members primarily in the form of services through a panel of health care providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers, except in cases of emergency or referral by a panel member.

"Custodial parent" means the parent awarded physical custody by a court order or, in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

"Plan" includes any of the following that provides benefits or services for medical or dental care or treatment: group and nongroup insurance contracts, health maintenance organization contracts, closed panel plans or other forms of group or group-type coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal government plan, as permitted by law. A "plan" does not include any of the following: hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; medical benefits under group or individual automobile contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

A. Order of Benefits Determination Rules. The order of benefits determination rules govern the order in which this Benefit Plan and another plan will pay benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The secondary plan may reduce the benefits it pays so that the benefits payable under all plans do not total more than 100% of the total allowable expense for Covered Services.

   A plan that does not contain a coordination of benefits provision that is consistent with this Benefit Plan's provision is always primary unless the rules of both plans state that this Benefit Plan is primary. An exception exists for coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

   If a Claim for Benefits or any other request for reimbursement is submitted under this Benefit Plan the order of payment will be the first of the following rules that apply:

   1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

      However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      a. Secondary to the plan covering the person as a dependent; and

      b. Primary to the plan covering the person as other than a dependent (e.g., a retired employee).

      Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

   2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

      a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

         (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

         (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph shall not apply with respect to any plan year during which Covered Services are paid or provided before the entity has actual knowledge of the court order provision. A copy of the court order must be provided to the Claims Administrator upon request;

(2) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Section 7.1(A.)(2.)(a.) shall determine the order of benefits;

(3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Section 7.1(A.)(2.)(a.) shall determine the order of benefits; or

(4) If there is no court order allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent;

b. The plan covering the custodial parent's spouse;

c. The plan covering the non-custodial parent; and then

d. The plan covering the non-custodial parent's spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Section 7.1(A.)(2.)(a.) or Section 7.1(A.)(2.)(b.) as if those individuals were parents of the child.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired, or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

   If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 7.1(A.)(1.) can determine the order of benefits.

4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber, policyholder or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Also, this rule does not apply if the rule in Section 7.1(A.)(1.) can determine the order of benefits.

5. Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended.

   The start of a new plan does not include:

   a. A change in the amount or scope of a plan's benefits;

   b. A change in the entity that pays, provides or administers the plan's benefits; or

   c. A change from one type of plan to another, such as from a single employer plan to a multiple employer plan.

   The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

B. If it is determined this Benefit Plan is secondary, the benefits of this Benefit Plan will be reduced so that the total benefits paid or provided by all plans during a Benefit Period are not more than the total allowable expenses. In determining the amount to be paid for any claim, this Benefit Plan will calculate the benefits it would have paid in the absence of coverage under another plan and apply that calculated amount to the allowable expense under this Benefit Plan that is unpaid by the primary plan. The benefits of this Benefit Plan will then be reduced so that they and the benefits payable under the other plans for the claim do not total more than 100% of the total allowable expense for that claim. When the benefits of this Benefit Plan are reduced as described in this subsection, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Benefit Plan. In addition, if this Benefit Plan has a deductible and/or coinsurance, the deductible and/or coinsurance will be credited with any amounts that would have been credited in the absence of the other plan.

The ultimate responsibility of the Claims Administrator for payment of Covered Services will never exceed the amount payable in the absence of other coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to administer this coordination of benefits provision and to determine benefits payable under this Benefit Plan and other plans. The Claims Administrator may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. The Claims Administrator need not tell, or obtain the consent of, any person to do this. Each Member claiming benefits under this Benefit Plan must provide the Claims Administrator with any facts it needs to administer this provision and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Benefit Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. The amount will then be treated as though it were a benefit paid under this Benefit Plan. The Claims Administrator will not have to pay that amount again.

RIGHT OF RECOVERY

If payments have been made by the Claims Administrator for Covered Services in excess of the amount payable under this Benefit Plan, the Claims Administrator may recover the excess from any persons to or for whom such payments were made, including any Member, provider or other organization. The Member agrees to execute and deliver any documentation requested by the Claims Administrator to recover excess payments.

## 7.2 AUTOMOBILE NO-FAULT OR MEDICAL PAYMENT BENEFIT APPLICATION

If a Member is eligible for basic automobile no-fault benefits or other automobile medical payment benefits as the result of accidental bodily injury arising out of the operation, maintenance or use of a motor vehicle, the benefits available under this Benefit Plan will be reduced by the basic automobile no-fault benefits or other automobile medical payment benefits.

## 7.3 MEDICAL PAYMENT BENEFIT COORDINATION

If a Member is eligible for medical payment benefits provided by any other collectible insurance as a result of an injury, the benefits available under this Benefit Plan will be reduced by and coordinated with the medical payment benefits provided by any other collectible insurance not prohibited from coordination of benefits.

## 7.4 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

If the Claims Administrator on behalf of the Group pays benefits for Covered Services to or for a Member for any injury or condition caused or contributed to by the act or omission of any third party, the Claims Administrator on behalf of the Group shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. The Claims Administrator has full discretionary authority to determine whether to exercise any or all of said rights.

**A Member must notify the Claims Administrator of the circumstances of the injury or condition, cooperate with the Claims Administrator in doing whatever is necessary to enable the Claims Administrator to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. The Claims Administrator has no obligation to notify a Member of the Claims Administrator's intent to exercise one or more of these rights and the Claims Administrator's failure to provide such a notice shall not constitute a waiver of these rights.**

If a Member does not comply with these provisions or otherwise prejudices the rights of the Claims Administrator on behalf of the Group to assignment, subrogation or reimbursement, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition. The Claims Administrator shall have full discretion to interpret these provisions and to determine their application in each and every situation. Any decisions by the Claims Administrator regarding the application of the above provisions shall be final, conclusive and binding upon all parties.

A. Right of Assignment and/or Subrogation: If a Member fails to bring a claim against a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), the Claims Administrator on behalf of the Group has the right to bring said claim as the assignee and/or subrogee of the Member and to recover any benefits paid under this Benefit Plan.

B. Right of Reimbursement: If a Member makes any recovery from a third party (including any person, firm or corporation which may be liable for or on behalf of the third party), whether by judgment, settlement or otherwise, the Member must notify the Claims Administrator of said recovery and must reimburse the Claims Administrator on behalf of the Group to the full extent of any benefits paid by the Claims Administrator, not to exceed the amount of the recovery. This right of reimbursement shall apply to any such recovery to the extent of any benefits paid under this Benefit Plan even if the Member has not received full compensation for the injury or condition. Any recovery the Member may obtain is conclusively presumed to be for the reimbursement of benefits paid by the Claims Administrator on behalf of the Group until the Claims Administrator has been fully reimbursed.

The Member agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid the rights of the Claims Administrator on behalf of the Group under this Benefit Plan. The Member agrees that any recovery shall be held in trust for the Claims Administrator on behalf of the Group until the Claims Administrator on behalf of the Group has been fully reimbursed and/or that the Claims Administrator on behalf of the Group shall have a lien on any recovery to the full extent of any benefits paid under this Benefit Plan. The Member agrees that to enforce its rights under this section, the Claims Administrator on behalf of the Group may pursue any and all remedies, legal or equitable, available under state or federal law, Including subrogation, breach of contract, constructive trust, equitable lien, injunction, restitution and any other remedies.

## 7.5 WORKERS' COMPENSATION

If benefits or compensation are available, in whole or in part, under provisions of a state workers' compensation act, laws of the United States or any state or political subdivision thereof, the benefits under this Benefit Plan will be reduced by and coordinated with such other benefits or compensation available to a Member.

If a Member is injured or suffers any condition caused or contributed to by the Member's employment, the Member must notify the Claims Administrator of the circumstances of the injury and condition, cooperate with the Claims Administrator and the United States or any state or political subdivision thereof in doing whatever is necessary to determine the availability of such benefits or compensation, and do nothing to prejudice them.

In the event of the failure of a Member to comply with this provision or if a Member prejudices that Member's right or entitlement to benefits or compensation available under such a program, the Claims Administrator shall have full discretion to withhold payment of any future benefits to or for the Member and to off set the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition.

## SECTION 8
## DEFINITIONS

This section defines the terms used in this Benefit Plan. These terms will be capitalized throughout this Benefit Plan when referred to in the context defined. The Claims Administrator shall have full discretion to interpret and determine the application of the Definitions in each and every situation. Any decisions by the Claims Administrator regarding the Definitions shall be final, conclusive and binding upon all parties.

**ADMISSION** - entry into a facility as an Inpatient or Outpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Member is discharged or released from the facility and is no longer registered as a patient.

**ALLOWANCE OR ALLOWED CHARGE** - the maximum dollar amount that payment for a procedure or service is based on as determined by the Claims Administrator.

**AMBULATORY (OUTPATIENT) SURGERY** - surgery performed in the outpatient department of a Hospital, Ambulatory Surgical Facility or Professional Health Care Provider's office.

**ANCILLARY SERVICES** - services required for the treatment of a Member in a Hospital, other than room, board and professional services.

**ANNUAL ENROLLMENT PERIOD** - a period of time an eligible employee or Eligible Dependent may apply for coverage under this Benefit Plan after the initial enrollment period. The Annual Enrollment Period will be a period of 31 days prior to the Group's anniversary date.

**AUTHORIZED REPRESENTATIVE** - a Health Care Provider or other individual authorized by the Member to inquire or request information on a Member.

**BEHAVIORAL MODIFICATION INTERVENTION FOR AUTISM SPECTRUM DISORDER (INCLUDING APPLIED BEHAVIOR ANALYSIS (ABA))** - the principles and techniques by a Licensed Behavior Analyst or Licensed Assisted Behavior Analyst to design, supervise, implement, modify and evaluate environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis.

**BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A claim will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.

**BENEFIT PLAN** - the agreement with the Claims Administrator, Including the Subscriber's application, Identification Card, the Service Agreement, this Summary Plan Description and any supplements, endorsements, attachments, addenda or amendments.

**BLUECARD PROGRAM** - The Blue Cross and Blue Shield Association, of which the Claims Administrator is an independent licensee, has implemented the BlueCard Program. This allows Members seeking medical services outside the Claims Administrator's (Home Plan) service area, access to the Health Care Provider discounts of the local Blue Cross and/or Blue Shield entity (Host Plan) participating in the BlueCard Program.

**CLAIM FOR BENEFITS** - a request for a benefit or benefits under the terms of this Benefit Plan made by a Member in accordance with the Claims Administrator's reasonable procedures for filing a Claim for Benefits as outlined in Section 6, Claims for Benefits, Appeals and Grievances. A Claim for Benefits includes Claims for Benefits requiring Precertification (Preservice Claim for Benefits) and all other Claims for Benefits (Post Service Claim for Benefits). A Claim for Benefits involving payment of a claim shall be made promptly and in accordance with state law.

**CLAIMS ADMINISTRATOR** - Blue Cross Blue Shield of North Dakota. Also referred to as BCBSND.

**CONTRACT TYPE** - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Contract Types are as follows:

A. **Individual Participation** - Subscriber only.

B. **Parent and Child Participation** - Subscriber and one eligible child.

C. **Parent and Children Participation** - Subscriber and eligible children.

D. **Two Person Participation** - Subscriber and spouse.

E. **Family Participation** - Subscriber and Eligible Dependents.

**COST SHARING AMOUNTS** - the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. See Section 1, Schedule of Benefits for the specific Cost Sharing Amounts that apply to this Benefit Plan.

A. **Coinsurance Amount** - a percentage of the Allowed Charge for Covered Services that is a Member's responsibility.

   The Claims Administrator shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Claims Administrator's service area on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

   When a Member receives Covered Services from a Nonparticipating Health Care Provider for which the Member must be protected from excess charges, the Claims Administrator shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services on the lesser of (1) billed charges or (2) the payment amount required by federal law. See Section 1.3, Selecting a Health Care Provider.

   If Covered Services are obtained by a Member out of the Claims Administrator's service area, the local Blue Cross Blue Shield Plan's (Host Plan) provider contract may require coinsurance calculation that is not based on the discounted price the Health Care Provider has agreed to accept from the Host Plan. Rather, it may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the Claims Administrator's service area. It is not possible to provide specific information for each out-of-area Health Care Provider because of the many different arrangements between Host Plans and Health Care Providers. However, if a Member contacts the Claims Administrator prior to incurring out-of-area services, the Claims Administrator may be able to provide information regarding specific Health Care Providers.

B. **Coinsurance Maximum Amount** - the total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period.

C. **Copayment Amount** - a specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service. Copayment Amounts do not apply toward the Out-of-Pocket Maximum Amount or the Prescription Medication or Drug Coinsurance Maximum Amount.

D. **Deductible Amount** - a specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period. The Deductible Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

E. **Out-of-Pocket Maximum Amount** - the total Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts and the Outpatient Prescription Medication or Drug Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

F. **Prescription Medication or Drug Coinsurance Maximum Amount** - the total Coinsurance Amount for Outpatient Prescription Medications or Drugs that is a Member's responsibility during a Benefit Period. When this Coinsurance Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Outpatient Prescription Medications or Drugs, less Copayment Amounts incurred during the remainder of the Benefit Period. This Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts and the Nonformulary Drug sanction do not apply toward this Coinsurance Maximum Amount.

G. **Infertility Services Deductible Amount** - a specified dollar amount payable by the Member during their lifetime for medical infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.

**COVERED SERVICE** - Medically Appropriate and Necessary services and supplies for which benefits are available when provided by a Health Care Provider.

**CUSTODIAL CARE** - care that the Claims Administrator in its sole discretion determines is designed essentially to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.

**DIABETES PREVENTION PROGRAM** - a 12-month lifestyle change program using the Centers for Disease Control's research-based approved curriculum for Members age 18 and older at a high risk of developing type 2 diabetes.

**DIABETES PREVENTION PROVIDER** - a Participating Health Care Provider, or an individual or entity affiliated or associated with a Participating Health Care Provider, using trained lifestyle coaches to provide a Diabetes Prevention Program.

**DIAGNOSTIC SERVICE** - a test or procedure provided because of specific symptoms and directed toward the determination of a definite condition. A Diagnostic Service must be ordered by a Professional Health Care Provider. Diagnostic Services include, but are not limited to X-ray and other imaging services, laboratory and pathology services, cardiographic, encephalographic and radioisotope tests.

**ELIGIBLE DEPENDENT** - a dependent of the Subscriber, or a dependent's dependent (grandchild), who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

A. The Subscriber's spouse under a legally existing marriage.

B. The Subscriber's or the Subscriber's living covered spouse's children under the age of 26 years. Children are considered under age 26 until the end of the month in which the child becomes 26 years of age. The term child or children includes:

    1. Children physically placed with the Subscriber for adoption or whom the Subscriber or the Subscriber's living, covered spouse has legally adopted.

    2. Children living with the Subscriber for whom the Subscriber or the Subscriber's living, covered spouse has been appointed legal guardian by court order.

    3. The Subscriber's grandchildren or those of the Subscriber's living, covered spouse if: (a) the parent of the grandchild is unmarried, (b) the parent of the grandchild is covered under this Benefit Plan and (c) the parent is primarily dependent on the Subscriber for support. If a lapse in coverage occurs due to ineligibility of the parent under this Benefit Plan, the grandchild cannot be reenrolled unless the Subscriber has been appointed legal guardian.

    4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits.

5. Children beyond the age of 26 who are incapable of self support because of intellectual disability or physical handicap that began before the child attained age 26 and who are primarily dependent on the Subscriber or the Subscriber's spouse for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Subscriber's dependent for federal income tax purposes. The Subscriber may be asked periodically to provide evidence satisfactory to the Claims Administrator of these disabilities.

**EMERGENCY MEDICAL CONDITION** - a medical condition, including a mental health condition or substance abuse disorder, manifesting itself by acute symptoms of sufficient severity that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

**EMERGENCY SERVICES** - include:

A. an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an Emergency Medical Condition exists; and

B. such further medical examination and treatment as may be required to stabilize a Member (regardless of the department of the Hospital in which further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department.

**EXPERIMENTAL OR INVESTIGATIVE** - a drug, device, medical service, treatment or procedure is Experimental or Investigative if:

A. the drug or device cannot be lawfully marketed without the 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; or

B. the drug, device, medical service, treatment or procedure, or the patient informed consent document utilized with the drug, device, medical service, treatment or procedure was reviewed and approved by the treating facility's institutional review board as required by federal law; or

C. the Claims Administrator in its sole discretion determines that there exists reliable evidence that the drug, device, medical service, treatment or procedure

    1. is the subject of ongoing phase 1 or phase 2 clinical trials,

    2. is the research, experimental, study or investigational arm of an ongoing phase 3 clinical trial, or

    3. is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. the Claims Administrator in its sole discretion determines that there exists reliable evidence with respect to the drug, device, medical service, treatment or procedure and that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of reliable treatment or diagnosis; or

E. the Claims Administrator in its sole discretion determines that based on prevailing medical evidence the drug, device, medical service, treatment or procedure is Experimental or Investigative.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical service, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical service, treatment or procedure.

**EXPLANATION OF BENEFITS** - a document sent to the Member by the Claims Administrator after a claim for reimbursement has been processed. It includes the patient's name, claim number, type of service, Health Care Provider, date of service, charges submitted for the services, amounts covered by this Benefit Plan, noncovered services, Cost Sharing Amounts and the amount of the charges that are the Subscriber's responsibility. This form should be carefully reviewed and kept with other important records.

**GROUP** - the Plan Sponsor that has signed an agreement with the Claims Administrator to provide health care benefits for its eligible employees and Eligible Dependents.

**HEALTH CARE PROVIDER** - Institutional or Professional Health Care Providers providing Covered Services to Members as listed below. The Health Care Provider must be licensed, registered or certified by the appropriate state agency where the Covered Services are performed and provided in accordance with the Health Care Provider's scope of licensure as provided by law. Where there is no appropriate state agency, the Health Care Provider must be registered or certified by the appropriate professional body. A Health Care Provider includes but is not limited to:

A. **Advanced Practice Registered Nurse** - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or Nurse Practitioner.

B. **Ambulance** - a specially designed or equipped vehicle used only for transporting the critically ill or injured to a health care facility. The ambulance service must meet state and local requirements for providing transportation for the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

C. **Ambulatory Surgical Facility** - a facility with an organized staff of Professional Health Care Providers that:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. provides treatment by or under the direct supervision of a Professional Health Care Provider;

3. does not provide inpatient accommodations; and

4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Health Care Provider.

D. **Audiologist**.

E. **Certified Diabetes Educator** (C.D.E.).

F. **Certified Peer Support Specialist I**.

G. **Certified Peer Support Specialist II**.

H. **Chiropractor** - a Doctor of Chiropractic (D.C.).

I. **Dentist** - a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

J. **Home Health Agency** - an agency providing, under the direction of a Professional Health Care Provider, skilled nursing and related services to persons in their place of residence.

K. **Home Infusion Therapy Provider**.

L. **Home Medical Equipment Supplier**.

M. **Hospice** - an organization that provides medical, social and psychological services in the home or inpatient facility as palliative treatment for patients with a terminal illness and life expectancy of less than 6 months.

N. **Hospital** - an institution that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Professional Health Care Providers.

O. **Independent Clinical Laboratory** - a medical laboratory providing Diagnostic Services that is approved for reimbursement by the Claims Administrator and is not affiliated or associated with a Hospital or Professional Health Care Provider otherwise providing patient services.

P. **Licensed Addiction Counselor**.

Q. **Licensed Assisted Behavior Analyst**.

R. **Licensed Behavior Analyst**.

S. **Licensed Clinical Psychologist** - a licensed psychologist with a doctorate degree in psychology who is eligible for listing in the National Register of Health Service Providers in Psychology.

T. **Licensed Clinical Social Worker (LCSW)**.

U. **Licensed Marriage and Family Therapist (LMFT)**.

V. **Licensed Master Social Worker (LMSW)**.

W. **Licensed Professional Clinical Counselor**.

X. **Licensed Professional Counselor**.

Y. **Licensed Registered Dietitian**.

Z. **Long Term Acute Care Facility** - a facility that provides long-term acute hospital care for medically complex conditions or specialized treatment programs.

AA. **Mobile Radiology Supplier**.

BB. **Occupational Therapist**.

CC. **Optometrist** - a Doctor of Optometry (O.D.).

DD. **Oral Pathologist** - a Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Pathologists.

EE. **Oral Surgeon** - a Doctor of Dental Surgery (D.D.S.) meeting all formal requirements for certification by the American Board of Oral Surgery.

FF. **Pain Treatment Facility** - a facility that has satisfied the CARF accreditation requirements of a chronic pain management program.

GG. **Pharmacist**.

HH. **Pharmacy** - an establishment where the profession of pharmacy is practiced by a Pharmacist.

II. **Physical Therapist**.

JJ. **Physician** - a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

KK. **Physician Assistant**.

LL. **Podiatrist** - a Doctor of Podiatry (D.P.), a Doctor of Surgical Chiropody (D.S.C.), a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Podiatry (D.S.P.).

MM. **Psychiatric Care Facility** - an institution or a distinct part of an institution providing diagnostic and therapeutic services for the inpatient treatment of mental illness under the direct supervision of a Professional Health Care Provider.

NN. **Rehabilitation Facility** - an institution or a distinct part of an institution providing Rehabilitative Therapy.

OO. **Respiratory Therapist**.

PP. **Skilled Nursing Facility** - an institution or a distinct part of an institution providing skilled nursing and related services to persons on an inpatient basis under the direct supervision of a Professional Health Care Provider.

QQ. **Sleep Lab**.

RR. **Speech Therapist**.

SS. **Substance Abuse Facility** - an institution or a distinct part of an institution providing diagnostic and therapeutic services for the Inpatient treatment of substance use disorder under the direct supervision of a Professional Health Care Provider.

TT. **Transitional Care Unit** - a sub-acute unit of a Hospital that provides skilled services necessary for the transition between Hospital and home or to a lower level of care.

**HOME HEALTH CARE** - Skilled Nursing Services, Physical Therapy, Occupational Therapy and Speech Therapy provided under active Physician and nursing management through a central administrative unit coordinated by a registered nurse to a Member in the Member's place of residence.

**HOME MEDICAL EQUIPMENT** - items that can withstand repeated use and are primarily used to serve a medical purpose outside of a health care facility. Such items would not be of use to a person in the absence of illness, injury or disease.

**IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Unique Member Identifier of the Member. If a Member is also enrolled in a primary Medicare Part D Plan, a card for this Benefit Plan may be issued in the Member's name.

**IMMEDIATE FAMILY** - a person who ordinarily resides in a Member's household or is related to the Member, Including a Member's parent, sibling, child or spouse, whether the relationship is by blood or exists in law.

**INCLUDING** - means including, but not limited to.

**INPATIENT** - a person confined as a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

**INSTITUTIONAL HEALTH CARE PROVIDER** - an Ambulance, Home Health Agency, Home Medical Equipment Supplier, Hospital, Long Term Acute Care Facility, Mobile Radiology Supplier, Pain Treatment Facility, Pharmacy, Psychiatric Care Facility, Rehabilitation Facility, residential treatment center, Skilled Nursing Facility, Sleep Lab, Substance Abuse Facility or Transitional Care Unit.

**INTENSIVE OUTPATIENT PROGRAM** - a structured, short term multidisciplinary treatment for psychiatric illness and/or substance abuse provided by a Health Care Provider. The treatment is more intensive than Outpatient treatment but less intensive than Partial Hospitalization.

**LIFETIME MAXIMUM** - the maximum amount of benefits, Including procedures, days, visits or dollars for certain Covered Services an eligible Member may receive during a lifetime while enrolled under a Benefit Plan sponsored by the Group. The benefit amounts received under all previous Benefit Plans sponsored by the Group will be applied toward the Lifetime Maximum for such Covered Services under this Benefit Plan.

**MAINTENANCE CARE** - treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. Exception: periodic reassessments are not considered Maintenance Care.

**MAXIMUM BENEFIT ALLOWANCE** - the maximum amount of benefits, Including procedures, days, visits or dollars available under this Benefit Plan for a specified Covered Service.

**MEDICALLY APPROPRIATE AND NECESSARY** - services, supplies or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria as determined by the Claims Administrator in its sole discretion:

A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the Member's illness or injury;

B. The services, supplies or treatments are consistent with professionally recognized standards of health care; and

C. The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the Member's illness or injury.

**MEMBER** - the Subscriber and, if another Contract Type is in force, the Subscriber's Eligible Dependents.

**NONPARTICIPATING HEALTH CARE PROVIDER** - a Health Care Provider that does not have a participation agreement with the Claims Administrator. Nonparticipating Health Care Providers (Including Psychiatric Care Facility, Substance Abuse Facility, Inpatient, Institutional Health Care Provider, Intensive Outpatient Program, Partial Hospitalization, or Residential Treatment) must meet the same programmatic, staffing and intensity of services treatment components as defined by the Claims Administrator for participating providers, and payment for these services will be specific to that level of care.

**NONPAYABLE HEALTH CARE PROVIDER** - a Health Care Provider that is not reimbursable by the Claims Administrator. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Nonpayable Health Care Provider.

**OFFICE VISIT** - a professional service, Including an examination for the purpose of diagnosing or treating an illness or injury or the determination, initiation or monitoring of a treatment plan provided in an outpatient setting by a Professional Health Care Provider.

**OPIOID TREATMENT PROGRAM** - a federally certified program using medication assisted treatment for treatment of opioid use disorder.

**ORTHOTIC DEVICES** - any rigid or semi-rigid supportive device that restricts or eliminates the motion of a weak or diseased body part.

**OUTPATIENT** - a person treated as a registered Outpatient at a Hospital, clinic or in a Professional Health Care Provider's office, who is not, at the time of treatment, a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

**PARTIAL HOSPITALIZATION** - continuous structured multidisciplinary treatment of mental illness or substance abuse by a Health Care Provider, usually held during the daytime hours and generally providing 20 or more hours per week to treat multidimensional instability not requiring 24-hour care.

**PARTICIPATING HEALTH CARE PROVIDER** - a Health Care Provider that has entered into a participation agreement with the Claims Administrator to provide Covered Services to a Member for an agreed upon payment.

**PARTICIPATING PHARMACY** - a Pharmacy, preferred mail order pharmacy or preferred specialty drug provider that has entered into an agreement with the Claims Administrator's preferred pharmacy network, preferred mail order pharmacy network or preferred specialty pharmacy network.

**PLAN ADMINISTRATOR** - the administrator of the Plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

**PRECERTIFICATION** - the process of the Member or the Member's representative notifying the Claims Administrator of the Member's intent to receive services requiring Precertification. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary in order to receive benefits for such services. Eligibility for benefits for services requiring Precertification is contingent upon compliance with the provisions of Section 3. Precertification does not guarantee payment of benefits.

**PRESCRIPTION MEDICATION OR DRUG** - any legend drug, Payable Over-the-Counter (OTC) Drug, biologic or insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of the disease or illness for which the Member is receiving care.

A. **Brand Name** - the registered trademark name of a Prescription Medication or Drug by its manufacturer, labeler or distributor.

B. **Formulary Drug** - a Brand Name or Generic Prescription Medication, Drug, or diabetes supply that is safe, therapeutically effective, high quality and cost effective as determined by a committee of Physicians and Pharmacists.

C. **Generic** - the established name or official chemical name of the drug, drug product or medicine.

D. **Nonformulary Drug** - a Prescription Medication, Drug, or diabetes supply that is not a Formulary Drug.

E. **Nonpayable Drug** - a Prescription Medication or Drug that is not reimbursed by the Claims Administrator or is included in Section 4, Exclusions.

F. **Payable Over-the-Counter (OTC) Drug** - a medication or drug approved by the U.S. Food and Drug Administration for marketing without a Prescription Order and approved by the Claims Administrator when dispensed by a Pharmacist upon the receipt of a Prescription Order.

G. **Restricted Use Drug** - a Prescription Medication or Drug that may require Precertification and/or be subject to a limited dispensing amount or a Step Therapy requirement.

H. **Specialty Drug** - an Outpatient Prescription Medication or Drug listed on the Specialty Drug list.

I. **Step Therapy** - the process of trying another proven, cost-effective medication before coverage may be available for the drug included in the Step Therapy program. Many Brand Name drugs have a less-expensive Generic or Brand Name alternative that might be an option. There must be documented evidence that another eligible medication in the same or different drug class has been tried before the Step Therapy medication will be paid under the Outpatient Prescription Medication or Drug benefit.

**PRESCRIPTION ORDER** - the order for a Prescription Medication or Drug issued by a Professional Health Care Provider licensed to make such order in the ordinary course of professional practice.

**PROFESSIONAL HEALTH CARE PROVIDER** - an Advanced Practice Registered Nurse, Audiologist, Certified Diabetes Educator, Certified Peer Support Specialist I, Certified Peer Support Specialist II, Chiropractor, Dentist, Home Infusion Therapy Provider, Licensed Addiction Counselor, Licensed Assisted Behavior Analyst, Licensed Behavior Analyst, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Master Social Worker, Licensed Professional Clinical Counselor, Licensed Professional Counselor, Licensed Registered Dietitian, Occupational Therapist, Optometrist, Oral Pathologist, Oral Surgeon, Pharmacist, Physical Therapist, Physician, Physician Assistant, Podiatrist, Respiratory Therapist or Speech Therapist as defined.

**PROSTHETIC APPLIANCE OR LIMB** - a fixed or removable artificial body part that replaces an absent natural part.

**PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:

A. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;
B. relates to a Member's past, present or future physical or mental health or condition;
C. relates to the provision of health care to a Member;
D. relates to the past, present, or future payment for health care to or on behalf of a Member; or
E. identifies a Member or could reasonably be used to identify a Member.

Educational records and employment records are not considered PHI under federal law.

**RESIDENTIAL TREATMENT** - 24-hour care under the clinical supervision of a Health Care Provider, in a residential treatment center other than an acute care hospital, for the active treatment of chemically dependent or mentally ill persons and to stabilize multidimensional imminent risk. Precertification is required.

**SELF-ADMINISTERED** - a Prescription Medication or Drug taken by mouth or injection that does not require professional administration.

**SKILLED NURSING SERVICES** - services that can be safely and effectively performed only by or under the direct supervision of licensed nursing personnel and under the direct supervision of a Professional Health Care Provider.

**SPECIAL CARE UNIT** - a section, ward or wing within a Hospital operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered nurses or other highly trained personnel, excluding any section, ward or wing within a Hospital maintained for the purpose of providing normal postoperative recovery treatment services.

**SUBSCRIBER** - an employee whose application for membership has been accepted, whose coverage is in force with the Claims Administrator and in whose name the Identification Card is issued. A Subscriber is an eligible employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled and actually covered under this Benefit Plan.

**SURGICAL SERVICES** - the performance of generally accepted operative and cutting procedures by a Professional Health Care Provider.

**TARGETED CASE MANAGEMENT** - services provided by a certified case manager to assist an individual with a serious mental illness or serious emotional disturbance with access to medical, social, educational and other services for appropriate care and treatment.

**TELEHEALTH** - the use of interactive audio, video or other telecommunications technology by a Health Care Provider at a Distant Site to deliver health care services at an Originating Site over a secure connection that complies with state and federal requirements and any other requirements established by the Claims Administrator. This includes the use of Store-and-Forward Technology. Telehealth does not include electronic mail, facsimile transmission or audio-only telephone except for the purpose of an E-visit or Virtual Check-in.

The following definitions apply to Telehealth:

**Distant Site** - a site at which a Health Care Provider or health care facility is located while providing medical services by means of Telehealth.

**E-visit** - a face-to-face digital communication initiated by a patient to a Health Care Provider through the Health Care Provider’s online patient portal.

**Originating Site** - a site at which a patient is located at the time health services are provided to the patient by means of Telehealth.

**Store-and-Forward Technology** - the electronic information, imaging and communication that is transferred, recorded or otherwise stored in order to be reviewed at a Distant Site at a later date by a Health Care Provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video and data communication.

**Virtual Check-in** - a brief communication via telephone or other telecommunications device to decide whether an Office Visit or other service is needed.

**THERAPY SERVICES** - the following services when provided according to a prescribed plan of treatment ordered by a Professional Health Care Provider and used for the treatment of an illness or injury to promote recovery of the Member:

A. **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents approved and administered in accordance with current literature and/or standard medical practice.

B. **Dialysis Treatment** - the process of diffusing blood across a semipermeable membrane to remove toxic materials and to maintain fluid, electrolyte and acid-base balance in cases of impaired kidney function or absence of the kidneys.

C. **Habilitative Therapy** - Habilitative Physical Therapy, Occupational Therapy or Speech Therapy is care provided for conditions which have limited the normal age appropriate motor, sensory or communication development. To be considered habilitative, therapy must help maintain or prevent deterioration of functional skills within a predictable period of time toward a Member's maximum potential.

   Functional skills are defined as essential activities of daily life common to all Members such as dressing, feeding, swallowing, mobility, transfers, fine motor skills, age appropriate activities and communication. Problems such as hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism spectrum disorders, traumatic brain injury, deaf-blindness, or multiple disabilities may warrant Habilitative Therapies.

D. **Occupational Therapy** - the treatment of physical or psychological dysfunction by or under the direct supervision of a licensed Occupational Therapist designed to improve and maximize independence in perceptual-motor skills, sensory integrative functioning, strength, flexibility, coordination, endurance, essential activities of daily life and preventing the progression of a physical or mental disability.

E. **Physical Therapy** - the treatment of disease, injury or medical condition by the use of therapeutic exercise and other interventions by or under the direct supervision of a licensed Physical Therapist that focuses on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, age appropriate motor skills, alleviating pain and preventing the progression of a physical or mental disability.

F. **Radiation Therapy** - the treatment of disease by the flow of a radiation beam of therapeutically useful radiant energy, through a defined area; Including emission of X-rays, gamma rays, electrons or other radiations from a treatment machine.

G. **Rehabilitative Therapy** - therapy designed to restore function following a surgery or medical procedure, injury or illness.

H. **Respiratory Therapy** - the introduction of dry or moist gases into the lungs when performed by or under the direct supervision of a registered or certified Respiratory Therapist.

I. **Speech Therapy** - the treatment of speech and language disorders that result in communication disabilities and swallowing disorders when provided by or under the direct supervision of a certified and licensed Speech Therapist. Speech Therapy services facilitate the development of human communications and swallowing through assessment, diagnosis and treatment when disorders occur due to disease, surgery, trauma, congenital anomaly or prior therapeutic process.

**UNIQUE MEMBER IDENTIFIER** - a number assigned by the Claims Administrator and listed on the Identification Card that identifies the Subscriber for administrative purposes.