Certificate of Insurance
& Summary Plan Description

**NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM
DAKOTA PLAN**

This Benefit Plan is a high deductible health plan designed to comply with Section 223 of the U.S. Internal Revenue Code and is intended for use with a Health Savings Account (HSA).

Blue Cross Blue Shield of North Dakota (BCBSND) is not authorized to provide legal or tax advice to Members. BCBSND expressly disclaims responsibility for, and makes no representation or warranty regarding: (1) the eligibility of any Member to establish or contribute to an HSA; or (2) the suitability of this product in all circumstances for use with HSAs.

January 1, 2012

High Deductible Health Plan

Health Care Coverage

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
NDPERS SERVICE CENTER

Questions?	Our Member Services staff is available to answer questions about your coverage –
Call Member Services:	Monday through Friday 8:00 a.m. - 5:00 p.m. CST (701) 282-1400 or 1-800-223-1704
North Dakota Relay Service:	1-800-366-6888
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
BCBSND Internet Address: **NDPERS Internet Address:**	www.BCBSND.com www.nd.gov/ndpers
Provider Directories:	Members can obtain a Provider Directory by calling the telephone numbers listed above or by visiting the BCBSND or NDPERS websites.

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Certificate of Insurance and 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 Certificate of Insurance and Summary Plan Description and the NDPERS 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 Certificate of Insurance and Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the 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.

BCBSND shall construe and interpret the provisions of the Service Agreement, the Certificate of Insurance and 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.

PLAN NAME

North Dakota Public Employees Retirement System - Dakota Plan HDHP

NAME AND ADDRESS OF EMPLOYER (PLAN SPONSOR)

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502

PLAN SPONSOR'S IRS EMPLOYER IDENTIFICATION NUMBER

45-0282090

PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

N/A

TYPE OF WELFARE PLAN

Health

TYPE OF ADMINISTRATION

This employee welfare benefit plan is fully insured by BCBSND and issued by BCBSND.

NAME AND ADDRESS OF BCBSND

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

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502
701-328-3900

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator:

Sparb Collins
North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, North Dakota 58502

BCBSND:

Daniel E. Schwandt
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.

TITLE OF EMPLOYEES AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION

Administrative Services Division
Benefit Programs Manager
Executive Director
Research & Plan Development Division
Accounting Division
Benefit Programs Division
Internal Auditor

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

State employees who are eighteen (18) years of age, whose services are not limited in duration, who is filling an approved and regularly funded position, and who is employed at least (20) hours per week and at least twenty weeks each year of employment are eligible to receive benefits. Temporary employees who work a minimum of 20 hours per week and at least 20 weeks each year are eligible to receive benefits. An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment. Each eligible employee may elect to enroll his/her Eligible Dependents. Eligible employees also include terminated employees and their Eligible Dependents who remain eligible to participate in the uniform group insurance program pursuant to applicable federal COBRA continuation regulations.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. BCBSND has the ultimate decision making authority regarding eligibility to receive benefits.

DESCRIPTION OF BENEFITS

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

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

The contributions for single or family coverage for state employees are paid at 100% by the state. The contributions for temporary employees are either at their own expense or their employer may pay the premium subject to its budget authority.

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

June 30

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INTRODUCTION

This Certificate of Insurance describes the health care benefits you have under the NDPERS Benefit Plan. The various Covered Services you receive are called your "benefits". All the benefits described are subject to all the terms, conditions, limitations and definitions included in the NDPERS Benefit Plan, as well as all provisions required by state law.

Participants in this employee health benefit plan are not vested. The benefit plan may be modified, amended or terminated by NDPERS and BCBSND at any time.

Anyone with any disability who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900.

In compliance with the Americans with Disabilities Act this document can be provided in alternate formats. If you require accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900.

If you have questions, please consult your employer for more specific information on your benefits. You may also call the Blue Cross Blue Shield of North Dakota's NDPERS Service Center at 1-800-223-1704 and 282-1400 for Fargo area Members. The North Dakota Relay Service toll-free number is 1-800-366-6888.

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 BCBSND.

Please review this Benefit Plan and retain it with your other important papers. If you are not satisfied with this Benefit Plan for any reason, you may return it to BCBSND within 10 days of its delivery to you and the premium paid will be refunded.

The Subscriber will receive an Identification Card displaying the Benefit Plan Number and other information about this Benefit Plan. All Members share this Benefit Plan Number. Carry the Identification Card at all times. If the Identification Card is lost, contact BCBSND to request a replacement. The Subscriber must not let anyone other than an Eligible Dependent, see definition 8.21, 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 of BCBSND. Participating Health Care Providers will submit claims on your behalf. You will be notified in writing by BCBSND of benefit payments made for Covered Services. Please review your Explanation of Benefits and advise BCBSND 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 benefits of the services you received within 18 months after services were provided. The written notice must include information necessary for BCBSND to determine benefits.

The Subscriber hereby expressly acknowledges and understands that BCBSND 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 BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND 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 BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to the Subscriber for any of BCBSND's obligations to the Subscriber created under this Benefit Plan. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this Benefit 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.

1.1 COST SHARING AMOUNTS

Cost Sharing Amounts include Coinsurance, 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, and the Benefit Plan Attachment for the specific Cost Sharing Amounts that apply to this Benefit Plan. All Members contribute to the Deductible and Coinsurance Amounts. Health Care Providers may bill you directly or request payment of Coinsurance and Deductible Amounts at the time services are provided.

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

	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$3,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$2,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$4,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$3,500 per Benefit Period	$3,000 per Benefit Period
Family Coverage	$7,000 per Benefit Period	$6,000 per Benefit Period

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

The benefit payment available under this Benefit Plan differs depending on the Subscriber’s choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider’s relationship with BCBSND:

Members should refer to the BCBSND website for a list of Health Care Providers or call Member Services at the telephone number on the back of the Identification Card for a provider directory. The website is continuously updated and is the most up-to-date listing of Health Care Providers.

PPO Plan

PPO stands for “Preferred Provider Organization” and is a group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge BCBSND less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts.

To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing.

Basic Plan

If a PPO Health Care Provider is not available in the Member’s area, or if the Member chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization, the Member will receive the Basic Plan benefits.

Other Health Care Providers

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 BCBSND 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 BCBSND.

When Covered Services are received from a Participating Health Care Provider, a provider discount provision is in effect. This means the Allowance paid by BCBSND 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 managed benefits requirements on behalf of the Member.

Nonparticipating Health Care Providers

If a Member receives Covered Services from a Nonparticipating Health Care Provider, the Member will be responsible for notifying BCBSND of the receipt of services. If BCBSND 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 managed benefits provisions. See Section 3, Managed Benefits.

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 and reduced by an additional 20%. The 20% payment reduction does not apply toward the Out-of-Pocket Maximum Amount. The Allowance will not exceed 80% of the billed charge.

   The Member is responsible for the 20% payment reduction and 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. BCBSND 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 BCBSND.

   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 BCBSND and the Health Care Provider. BCBSND 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 BCBSND.

Nonpayable Health Care Providers

If BCBSND 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.

Inter-Plan Programs

BCBSND has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Member obtains health care services outside of the BCBSND service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the BCBSND service area, a Member will obtain care from health care providers that have a contractual agreement (i.e., “participating agreement”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, a Member may obtain care from health care providers who have not entered into a “participating agreement” with a Host Blue. BCBSND payment practices in both instances are described below.

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 the health care providers who have entered into a “participating agreement” with it (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 billed charges for Covered Services, or
- The negotiated price that the Host Blue makes available to BCBSND.

Often, this "negotiated price" will consist of a simple discount, which reflects an actual price paid by the Host Blue. But 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, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSND uses for the Member's claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSND would then calculate the Member's liability for any Covered Services according to applicable law.

2. **Nonparticipating Providers Outside the BCBSND Service Area**

When Covered Services are provided outside of BCBSND's service area by health care providers who have not entered into a "participating agreement" with a Host Blue (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 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.

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, as permitted under Inter-Plan Programs Policies, 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.

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 Preauthorization and Prior Approval requirements will apply. If the Health Care Provider is a Participating Provider with the BlueCard Program, the Participating Health Care Provider will submit claims for reimbursement on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider. If the Health Care Provider does not participate with the BlueCard Program the Member will be responsible for payment of services and submitting a claim for reimbursement to BCBSND. BCBSND will provide translation and currency conversion services for the Member's claims outside of the United States.

BCBSND 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.

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 BCBSND will limit its payment to the amount BCBSND 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 BCBSND.

1.4 WAITING PERIODS FOR PREEXISTING CONDITIONS FOR LATE ENROLLEES

Members accepted as Late Enrollees will not be eligible for benefits for any services, supplies or charges for the care or treatment the Member receives for a Preexisting Condition during a period of 12 months following the individual Member’s effective date of this Benefit Plan. However, this waiting period may be reduced by aggregate days of membership under Qualifying Previous Coverage, if continuous until at least 63 days prior to the individual Member’s Enrollment Date under this Benefit Plan. Members under age 19 will not be subject to a Waiting Period.

1.5 OUTLINE OF COVERED SERVICES

This outline of Covered Services describes the Covered Services and the level of payment for the Covered Services. **For a description of the Covered Services, see page 14.**

PPO Plan: Benefits for Covered Services received by Eligible Dependents, see definition 8.21, who are residing out-of-area will be paid at the Basic level if the Subscriber or the Subscriber's spouse is required by court order to provide health coverage for that Eligible Dependent. You may be asked to provide a copy of the court order to BCBSND.

	Provider of Service:	
Covered Services	**Basic Plan After Deductible Amount**	**PPO Plan After Deductible Amount**
Inpatient Hospital and Medical Services		
• Inpatient Hospital Services	75% of Allowed Charge.	80% of Allowed Charge.
• Inpatient Medical Care Visits	75% of Allowed Charge.	80% of Allowed Charge.
• Ancillary Services	75% of Allowed Charge.	80% of Allowed Charge.
• Inpatient Consultations	75% of Allowed Charge.	80% of Allowed Charge.
• Concurrent Services	75% of Allowed Charge.	80% of Allowed Charge.
• Initial Newborn Care	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
Inpatient and Outpatient Surgical Services		
• Professional Health Care Provider Services	75% of Allowed Charge.	80% of Allowed Charge.
• Assistant Surgeon Services	75% of Allowed Charge.	80% of Allowed Charge.
• Ambulatory Surgical Facility Services	75% of Allowed Charge.	80% of Allowed Charge.
• Hospital Ancillary Services	75% of Allowed Charge.	80% of Allowed Charge.
• Anesthesia Services	75% of Allowed Charge.	80% of Allowed Charge.
Transplant Services	Benefits are subject to a Lifetime Maximum of 2 transplant procedures for the same condition.	
• Inpatient and Outpatient Hospital and Medical Services	75% of Allowed Charge when Prior Approval is received from BCBSND.	80% of Allowed Charge when Prior Approval is received from BCBSND.
• Transportation Services	75% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of $1,000 per transplant procedure.	80% of Allowed Charge.

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment		
• Surgical Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Lifetime Maximum of $10,000 per Member.	
• Nonsurgical Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Lifetime Maximum of $2,500 per Member.	
Outpatient Hospital and Medical Services		
• Home and Office Visits	75% of Allowed Charge.	80% of Allowed Charge.
• Diagnostic Services	75% of Allowed Charge.	80% of Allowed Charge.
• Emergency Services	80% of Allowed Charge for emergency room facility fee billed by a Hospital.	80% of Allowed Charge for emergency room facility fee billed by a Hospital.
	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider.	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider.
	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.
• Dental Services Related to Accidental Injury	75% of Allowed Charge.	80% of Allowed Charge.
• Radiation Therapy and Chemotherapy	75% of Allowed Charge.	80% of Allowed Charge.
• Dialysis Treatment	75% of Allowed Charge.	80% of Allowed Charge.
• Home Infusion Therapy Services	75% of Allowed Charge.	80% of Allowed Charge.
• Visual Training for Members under age 10	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Lifetime Maximum of 16 visits per Member.	
• Allergy Services	75% of Allowed Charge.	80% of Allowed Charge.
• Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Maximum Benefit Allowance of $3,000 per Member per Benefit Period.	
• Dental Anesthesia and Hospitalization	75% of Allowed Charge. Prior Approval is required for all Members age 9 and older.	80% of Allowed Charge. Prior Approval is required for all Members age 9 and older.

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Wellness Services		
• Well Child Care to the Member's 6th birthday	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for Well Child Care according to guidelines supported by the Health Resources and Services Administration, Including: • 7 visits for Members from birth through 12 months; • 4 visits for Members from 13 months through 35 months; • 1 visit per Benefit Period for Members 36 months through 72 months.	
• Immunizations	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	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, Influenza Virus, Tetanus, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.	
• Preventive Screening Services for Members age 6 and older	Benefits are available for preventive screening services according to A or B Recommendations of the U.S. Preventive Services Task Force, Including:	
Routine Physical Examination (Office Visit)	100% of Allowed Charge subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period. Deductible Amount is waived.	100% of Allowed Charge subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period. Deductible Amount is waived.
Routine Diagnostic Screenings: ➢ Adult Aortic Aneurysm Screening for male Members age 65 and older ➢ Lipid Disorders Screening once every 5 years ➢ Osteoporosis Screening for female Members once every 2 years ➢ Sexually Transmitted Disease (STD) Screening ➢ Type 2 Diabetes Mellitus Screening	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Mammography Screening	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	• One service for Members between the ages of 35 and 40; • One service per year for Members age 40 and older.	
Cervical Cancer Screening	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	Benefits are subject to a Maximum Benefit Allowance of 1 pap smear per Benefit Period.	
Related Office Visit	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
Colorectal Cancer Screening for Members age 50 through 75:		
➢ Fecal Occult Blood Testing – subject to a Maximum Benefit Allowance of 1 test per Benefit Period; and	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
➢ Colonoscopy – subject to a Maximum Benefit Allowance of 1 test every 10 years; or	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
➢ Sigmoidoscopy – subject to a Maximum Benefit Allowance of 1 test every 5 years.	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
Prostate Cancer Screening	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
	Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for an asymptomatic male age 50 and older, a black male age 40 and older, and a male age 40 and older with a family history of prostate cancer.	
Related Office Visit	75% of Allowed Charge. Deductible Amount is waived.	80% of Allowed Charge. Deductible Amount is waived.
Nutritional Counseling	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
	• Hyperlipidemia – Maximum Benefit Allowance of 4 visits per Member per Benefit Period. • Gestational Diabetes – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.	

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount

- Diabetes Mellitus – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.
- Hypertension – Maximum Benefit Allowance of 2 visits per Member per Benefit Period.
- Obesity – Maximum Benefit Allowance of 4 visits per Member per Benefit Period.

Benefits other than those recommended by the U.S. Preventive Services Task Force will be subject to Cost Sharing Amounts. See Outpatient Hospital and Medical Services.

A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member.

Covered Services	Basic Plan	PPO Plan
• Outpatient Nutritional Care Services	75% of Allowed Charge.	80% of Allowed Charge.

Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions:

- Chronic Renal Failure – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Anorexia Nervosa – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- Bulimia – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- PKU – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.

Covered Services	Basic Plan	PPO Plan
• Diabetes Education Services	75% of Allowed Charge.	80% of Allowed Charge.
• Dilated Eye Examination (for diabetes related diagnosis)	75% of Allowed Charge.	80% of Allowed Charge.

Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
• Tobacco Cessation Services Prescription Non-Nicotine Replacement Therapy Payable Over-the-Counter (OTC) Nicotine Replacement Therapy (nicotine lozenges, patches, gum) Prescription Nicotine Replacement Therapy (nicotine nasal spray, inhaler, patches)	Tobacco cessation services obtainable with a Prescription Order are paid at 100% of Allowed Charge. Deductible Amount is waived. Benefits are subject to a Maximum Benefit Allowance of 2 quit attempt cycles per Member per Benefit Period. A quit attempt cycle includes 4 counseling visits and/or a 3-month supply of nicotine or non-nicotine replacement therapy.	
Related Office Visit	100% of Allowed Charge. Deductible Amount is waived.	100% of Allowed Charge. Deductible Amount is waived.
Outpatient Therapy Services		
• Physical Therapy	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to the medical guidelines established by BCBSND.	
• Occupational Therapy	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• Speech Therapy	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• Respiratory Therapy Services	75% of Allowed Charge.	80% of Allowed Charge.
• Cardiac Rehabilitation Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions: • Myocardial Infarction • Coronary Artery Bypass Surgery • Coronary Angioplasty and Stenting • Heart Valve Surgery • Heart Transplant Surgery Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.	

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
• Pulmonary Rehabilitation Services	75% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a Lifetime Maximum of 3 visits per Member.	
Chiropractic Services		
• Home and Office Visits	75% of Allowed Charge.	80% of Allowed Charge.
• Therapy and Manipulations	75% of Allowed Charge.	80% of Allowed Charge.
• Diagnostic Services	75% of Allowed Charge.	80% of Allowed Charge.
Maternity Services		
• Inpatient Hospital and Medical Services	75% of Allowed Charge.	80% of Allowed Charge.
• Prenatal and Postnatal Care	75% of Allowed Charge.	80% of Allowed Charge.
• 1 Prenatal Nutritional Counseling visit per pregnancy	75% of Allowed Charge. .	80% of Allowed Charge.
Infertility Services	80% of Allowed Charge.	80% of Allowed Charge.
	Benefits are subject to a $20,000 Lifetime Maximum per Member. Prior Approval is required.	
Psychiatric and Substance Abuse Services		
• Inpatient Services	75% of Allowed Charge. Preauthorization is required.	80% of Allowed Charge. Preauthorization is required.
• Ambulatory Behavioral Health Care (Partial Hospitalization) Services	75% of Allowed Charge. Preauthorization is required.	80% of Allowed Charge. Preauthorization is required.
• Psychiatric Residential Treatment Services for Members under age 21	75% of Allowed Charge. Preauthorization is required.	80% of Allowed Charge. Preauthorization is required.
• Substance Abuse Residential Treatment Services	75% of Allowed Charge. Preauthorization is required.	80% of Allowed Charge. Preauthorization is required.
• Outpatient Services		
Psychiatric Services	80% of Allowed Charge.	80% of Allowed Charge.
Substance Abuse Services	80% of Allowed Charge.	80% of Allowed Charge.
Ambulance Services	75% of Allowed Charge.	80% of Allowed Charge.
Skilled Nursing Facility Services	75% of Allowed Charge.	80% of Allowed Charge.

Covered Services	Provider of Service: Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
Home Health Care Services	75% of Allowed Charge.	80% of Allowed Charge.
Hospice Services	75% of Allowed Charge.	80% of Allowed Charge.
Private Duty Nursing Services	75% of Allowed Charge.	80% of Allowed Charge.
Medical Supplies and Equipment	75% of Allowed Charge.	80% of Allowed Charge.
• Home Medical Equipment • Prosthetic Appliances and Limbs • Orthotic Devices • Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Outpatient Prescription Medications or Drugs • Oxygen Equipment and Supplies • Ostomy Supplies		
• Hearing aids for Members under age 18	Subject to a $3,000 Maximum Benefit Allowance per Member every 3 years.	
Eyeglasses or Contact Lenses (following a covered cataract surgery)	75% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.	80% of Allowed Charge.
Outpatient Prescription Medications or Drugs and Diabetes Supplies		
• Formulary Drug	80% of Allowed Charge.	
• Nonformulary Drug	50% of Allowed Charge.	

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 Medications or Drugs and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

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 and Benefit Plan Attachment.

BCBSND shall determine the interpretation and application of the Covered Services in each and every situation.

2.1 INPATIENT HOSPITAL AND MEDICAL SERVICES

Preauthorization may be required for Inpatient Hospital Admissions. See Section 3, Managed Benefits.

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. Prior Approval 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, except inpatient stays related to surgery or maternity care. See Section 2.2, Inpatient and Outpatient Surgical Services and Section 2.9, Maternity Services. Benefits are available for inpatient medical care visits for the treatment of mental illness or substance abuse only when provided in conjunction with a covered inpatient psychiatric or substance abuse Admission.

2. Consultation services by another Professional Health Care Provider 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 BCBSND, 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. Surgery for morbid obesity when Prior Approval is received from BCBSND. Benefits are subject to a Lifetime Maximum of 1 operative procedure for morbid obesity per Member. Guidelines and criteria are available upon request.

   No benefits are available for the repair or modification of any or all types of surgical morbid obesity procedures, except a Lifetime Maximum of 1 revision will be allowed per Member due to technical staple line failure. Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of surgical morbid obesity procedures are available only when Prior Approval is received from BCBSND.

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. Prior Approval is required.

   1. Heart
   2. Heart-lung
   3. Lung (single or double)
   4. Liver
   5. Pancreas
   6. Small bowel
   7. Kidney - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
   8. Cornea - Prior Approval is not required. Preauthorization may be required, see Section 3.2.
   9. Bone marrow/stem cell transplants with related services and supplies are covered subject to medical policy or medical guidelines.

   Please contact BCBSND 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 BCBSND, 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, if the living donor is not eligible for any other medical coverage.

   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 BCBSND. Benefits are subject to the Lifetime Maximum 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 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 Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. Covered Services 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 BCBSND 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 sole source of nutrition for a Member.

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 BCBSND. Guidelines and criteria for Medically Appropriate and Necessary services are available from a Participating Health Care Provider or BCBSND.

L. Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU) subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. 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. Prior Approval is required for all Members age 9 and older.

2.6 WELLNESS SERVICES

A. Well child care for Members to their 6th birthday according to the guidelines supported by the Health Resources and Services Administration and in accordance with the schedule listed in the Schedule of Benefits, Section 1.

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

C. Preventive screening services for Members age 6 and older according to A or B Recommendations of the U.S. Preventive Services Task Force, Including those services listed in the Schedule of Benefits, Section 1. A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member.

D. Outpatient nutritional 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.

E. Diabetes care services include 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. Benefits are subject to the Maximum Benefit Allowances as listed in the Schedule of Benefits, Section 1.

F. 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. Physical Therapy: Benefits will be based on a predetermined number of visits (also referred to as "window periods") according to the condition. Additional visits beyond the window period require Preauthorization from BCBSND. See Section 3, Managed Benefits. 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. Occupational Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a licensed Occupational 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.

C. Speech Therapy: Benefits are available as listed in the Schedule of Benefits, Section 1, when performed by or under the direct supervision of a certified and 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.

D. 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.

E. Cardiac rehabilitation services subject to the criteria listed in the Schedule of Benefits, Section 1.

F. Pulmonary rehabilitation services subject to the Lifetime Maximum listed in the Schedule of Benefits, Section 1.

2.8 CHIROPRACTIC SERVICES

Chiropractic services provided on an inpatient or outpatient basis when Medically Appropriate and Necessary as determined by BCBSND 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 1 ultrasound 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 nutritional counseling is limited to one prenatal visit per pregnancy.

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, and no later than the 34th 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, Benefit Plan Number 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 Benefit Plan Number, 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 BCBSND. In administering this Benefit Plan, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

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

2.11 PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES

A. Inpatient Services

Benefits are available for the inpatient treatment of mental illness and substance abuse when provided by a Hospital, Psychiatric Care Facility or Substance Abuse Facility. Preauthorization is required.

All out-of-state Admissions require Prior Approval from BCBSND.

B. Ambulatory Behavioral Health Care (Partial Hospitalization) Services

Benefits are available for Ambulatory Behavioral Health Care Services received through a Partial Hospitalization or intensive outpatient program for mental illness and substance abuse. Preauthorization is required.

C. Psychiatric Residential Treatment Services

Benefits are available for Residential Treatment services received through a Residential Treatment program. Preauthorization is required.

D. Substance Abuse Residential Treatment Services

Benefits are available for Residential Treatment services received through a Residential Treatment program. Preauthorization is required.

E. Outpatient Psychiatric Services

Benefits include diagnostic, evaluation and treatment services when provided by a Physician, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker and treatment services provided by a Psychiatric Nurse.

Group psychotherapy services received by a Member through a program approved by BCBSND.

F. Outpatient Substance Abuse Services

Benefits include diagnostic, evaluation and treatment services provided by a Physician, Licensed Clinical Psychologist or Licensed Addiction Counselor.

Group psychotherapy services received by a Member through a program approved by BCBSND.

G. **BCBSND 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 BCBSND.

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. Preauthorization is required. Benefits are not available for Maintenance Care or Custodial Care.

2.14 HOME HEALTH CARE SERVICES

Home Health Care when provided to an essentially homebound 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 BCBSND prior to Admission to Home Health Care. Benefits are available only if, in the absence of Home Health Care, the Member would require Inpatient Hospital or Skilled Nursing Facility Services. Preauthorization 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. Preauthorization is required.

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 BCBSND 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 Prior Approval is received from BCBSND. 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.

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 BCBSND.

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 OUTPATIENT PRESCRIPTION MEDICATIONS OR DRUGS

Benefits are available for Prescription Medications or Drugs approved by BCBSND 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 the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

All FDA approved Prescription Medications or Drugs and diabetes supplies will be categorized by BCBSND as a Formulary Drug, Nonformulary Drug, Nonpayable Drug, Restricted Use Drug or Payable Over-the-Counter (OTC) Drug. Prior Approval may be required for Restricted Use Drugs. Benefits may vary based on the various categories. A list of the various categories of Prescription Medications or Drugs 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.

BCBSND 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 Benefits when services are received at a Participating Pharmacy, charges in excess of the Allowed Charge are the Subscriber's responsibility.

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 BCBSND. 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 BCBSND Preferred Pharmacy Network.

SECTION 3
MANAGED BENEFITS

This section describes BCBSND's managed benefits programs and the Member's responsibilities under these programs. 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. BCBSND only has the authority to determine the extent of benefits available for Covered Services under this Benefit Plan.**

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

A Member seeking Covered Services from a Health Care Provider requiring either Prior Approval or Preauthorization 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 and Appeals.

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.

The managed benefits provisions of this Benefit Plan provide that care must be provided or authorized by the Network chosen by the Subscriber. The Network assumes responsibility for the coordination of a Member's health care needs and that the health care system is properly accessed and utilized. However, if a Member seeks care on a Self-Referral basis without an Authorized Referral from the Network, compliance with the following Managed Benefits Provisions becomes the responsibility of the Member.

3.1 PRIOR APPROVAL PROCESS

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

A. assisted reproductive technology for GIFT, ZIFT, ICSI and IVF;
B. chronic pain management program;
C. cosmetic surgeries;
D. dental anesthesia and hospitalization for all Members age 9 and older;
E. electric wheelchairs;
F. growth hormone therapy/treatment;
G. human organ and tissue transplants, except kidney and cornea transplants;
H. insulin infusion pump;
I. morbid obesity surgery;
J. obstructive sleep apnea treatment, except for Continuous Positive Airway Pressure (CPAP);
K. osseointegrated implants;
L. Prosthetic Limb replacement within 5 years;
M. psychiatric or substance abuse Admissions out-of-state;
N. Restricted Use Drugs;
O. rhinoplasty;
P. sleep studies; and
Q. weight loss Prescription Medications or Drugs.

To request Prior Approval, the Member or the Member's Health Care Provider, on the Member's behalf, must notify BCBSND of the Member's intent to receive services requiring Prior Approval. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary. This information must be submitted in writing from the Member's Health Care Provider.

A Member seeking Covered Services requiring Prior Approval 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 Prior Approval 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 Prior Approval does not guarantee payment of benefits. All services provided are subject to further review by BCBSND 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 BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

Prior Approval is required prior to obtaining services.

Information on the guidelines and criteria for Prior Approval are available from Participating Health Care Providers and BCBSND upon written request.

3.2 PREAUTHORIZATION

Preauthorization to BCBSND is required by each Member or the Member's representative prior to services being provided for the following services:

- Inpatient Admissions to a Health Care Provider not participating with BCBSND;
- Skilled Nursing Facility;
- Long Term Acute Care Facility;
- Transitional Care Unit;
- Inpatient Admission to a Rehabilitation Facility;
- Hospice;
- Home Health Care; and
- Psychiatric and Substance Abuse Admissions, including Ambulatory Behavioral Health Care (Partial Hospitalization) or Residential Treatment. All out-of-state Admissions require Prior Approval from BCBSND. See Section 3.1.

Admissions for maternity services do not require Preauthorization.

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

Notification Responsibility

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

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

BCBSND will issue a notice of authorization, partial authorization or denial of authorization following review of the Preauthorization request.

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

A Member seeking Covered Services requiring Preauthorization 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 Preauthorization 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 Preauthorization does not guarantee payment of benefits. All services provided are subject to further review by BCBSND 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 BCBSND. Benefits for authorized services are subject to the definitions, conditions, limitations and exclusions of this Benefit Plan.

3.3 CONCURRENT REVIEW

Concurrent review is the ongoing review of the Medical Appropriateness and Necessity of the required Admissions outlined in Section 3.2 to an Institutional Health Care Provider. BCBSND will monitor the inpatient Admission to determine whether benefits will be available for continued inpatient care.

If BCBSND determines benefits are not available because the continued stay is not Medically Appropriate and Necessary, BCBSND 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 BCBSND's notice of the termination of benefits.

3.4 DISCHARGE PLANNING

Discharge planning is the process of assessing the availability of benefits after a hospitalization. BCBSND 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.

3.5 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.

Benefits under case management may be provided if BCBSND determines that the services are Medically Appropriate and Necessary, cost effective and feasible and that the total benefits for services do not exceed the Lifetime Maximum that the Member would otherwise be entitled to under this Benefit Plan.

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. BCBSND shall determine the interpretation and application of the Exclusions in each and every situation.

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, counseling, therapy or care for learning disorders or mental retardation.
5. Sex therapy services or therapy for marital or family dysfunction.
6. Bereavement, codependency, marital dysfunction, family dysfunction, sex or interpersonal relationship counseling services.
7. Counseling services for the treatment of a gambling addiction or nicotine addiction.
8. Any drug, device, medical service, treatment or procedure that is Experimental or Investigative.
9. Services, treatments or supplies that BCBSND determines are not Medically Appropriate and Necessary.
10. Human organ and tissue transplants, except as specified in this Benefit Plan. Benefits are not available for donor organs or tissue other than human donor organs or tissue.
11. Services that are related to annual, periodic or routine examinations, except as specifically allowed in the Covered Services Section of this Benefit Plan.
12. Immunizations, testing or other services required for foreign travel.
13. Inpatient services performed primarily for diagnostic examinations, Physical Therapy, rest cure, convalescent care, Custodial Care, Maintenance Care or sanitaria care.

14. Services by 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 or a facility for the housing or rehabilitation of alcoholics or drug dependent persons.

    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.

15. The surgical or nonsurgical treatment of temporomandibular (TMJ) or craniomandibular (CMJ) joint disorder(s) when charges exceed the limits covered by this Benefit Plan. No benefits will be provided for orthodontic services (except as determined Medically Appropriate and Necessary) or osseointegrated implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).

16. Treatment leading to or in connection with sex change or transformation surgery and related complications.

17. 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.

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

19. 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.

20. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or 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.

21. 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.

22. Medical treatment and dietary management programs for obesity, except as specifically allowed in the Covered Services Section of this Benefit Plan. Benefits for surgical services performed for the treatment of morbid obesity are available only when Prior Approval is obtained from BCBSND. Benefits are subject to a Lifetime Maximum of 1 operative procedure per Member. A Lifetime Maximum of 1 revision will be allowed per Member due to technical staple line failure. Benefits are not provided for repair or modification of a gastric bypass/banding procedure.

23. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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

25. Biofeedback services.

26. Acupuncture services.

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

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

29. 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 BCBSND.

30. 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 diabetes or circulatory disorders of the legs or feet.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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.

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

40. 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.

41. Telephone consultations or charges for failure to keep a scheduled visit or charges for completion of any forms required by BCBSND.

42. Personal hygiene and convenience items, Including air conditioners, humidifiers or physical fitness equipment.

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

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

45. Electronic speech aids, artificial organs, donor search services or organ procurement if the organ or tissue is not donated.

46. Prosthetic Limbs or components intended only for cosmetic purposes, deluxe prosthetic knees controlled by microprocessors 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.

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

48. 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.

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

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

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

52. Cost Sharing Amounts.

53. Services when Prior Approval was required but not obtained.

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

55. Massage therapy provided by a masseuse or masseur.

56. 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.

57. Collection and storage of umbilical cord blood.

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

SECTION 5
GENERAL PROVISIONS

5.1 TIME LIMIT ON CERTAIN DEFENSES

The validity of this Benefit Plan may not be contested, except for nonpayment of premiums, after it has been in force for 2 years, beginning on the individual Member's effective date. Further, the validity of this Benefit Plan may not be contested on the basis of a statement made relating to insurability by any Member after continuous coverage has been in force for 2 years during the Member's lifetime unless the statement is written and signed by such Member. This time limit does not apply to fraudulent misstatements.

5.2 HEALTH SAVINGS ACCOUNT ELIGIBILITY

This Benefit Plan is intended to be compatible with Health Savings Accounts (HSAs) as described in Section 223 of the U.S. Internal Revenue Code, which means the Benefit Plan is designed to comply with federal law requirements regarding Deductible Amounts and Out-of-Pocket Maximum Amounts. If a Member desires to establish an HSA, the Member must enter into a separate written agreement with an HSA trustee or custodian. Since HSAs are personal health care savings vehicles, BCBSND is unable to provide legal or tax advice as to whether Members are eligible to establish or contribute to an HSA in any tax year.

In addition, although a Member must be covered by a high deductible health plan in order to contribute to an HSA, additional rules apply. Members may not contribute to an HSA, for example, if the Member can be claimed as a dependent on someone else's tax return or has other health coverage (other than high deductible coverage), including Medicare, coverage through a spouse, or coverage under a cafeteria plan that provides reimbursement of medical expenses. Members are solely responsible for determining the legal and tax implications of: (1) establishing an HSA; (2) eligibility for an HSA; (3) the amount of contributions made to an HSA; (4) the deductibility of contributions made to an HSA; and (5) withdrawals from an HSA and related taxation. BCBSND encourages Members to consult with an accountant, lawyer or other qualified tax adviser about how the rules apply to their own situations.

5.3 MEMBER BILL AUDIT

Upon receiving notice of a claims payment from BCBSND, the Member is encouraged to audit their medical bills and notify BCBSND of any services which are improperly billed or services that the Member did not receive. If, upon audit of a bill an error of $40 or more is found, the Member will receive a minimum payment of $20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of $500.

To obtain payment through the Member Bill Audit Program, the Subscriber must complete a Member Bill Audit Refund Request Form. Forms are available from Blue Cross Blue Shield of North Dakota’s NDPERS Service Unit.

This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim.

5.4 STATUS OF MEMBER ELIGIBILITY

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

Statements made on membership applications are deemed representations and not warranties. No statements made on the membership 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 membership application at the time of completion.

A Member making a statement (including the omission of information) on the membership 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 BCBSND. 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.

5.5 PHYSICAL EXAMINATIONS

BCBSND at its own expense may require a physical examination of the Member as often as necessary during the pendency of a Claim for Benefits and may require an autopsy in case of death if the autopsy is not prohibited by law.

5.6 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 BCBSND's receipt of a Claim for Benefits or later than 3 years after the expiration of the time within which notice of a Claim for Benefits is required by this Benefit Plan.

5.7 PREMIUM REFUND/DEATH OF THE SUBSCRIBER

In the event of the Subscriber's death, BCBSND will refund one-half month's premium if death occurred prior to the sixteenth of the month and all premiums paid beyond the month of the Subscriber's death, within 31 days after receiving notice of the death.

5.8 NOTIFICATION REQUIREMENTS AND SPECIAL ENROLLMENT PROVISIONS

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within 31 days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) 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 a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period and the Eligible Dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

     If the membership application is submitted within 31 days of the date of marriage, the effective date of coverage for the Eligible Dependent will be the first of the month immediately following the date of marriage. If the membership application is not submitted within 31 days of the date of marriage and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

  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 31 days of legal separation, divorce, annulment or death to be eligible for continued health coverage. See Section 5.9.

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

     The Subscriber's spouse must apply within 31 days of legal separation, divorce, annulment or death to be eligible for continuous health coverage under a separate benefit plan. If the Subscriber's spouse does not submit a membership application within 31 days, continuous health coverage under a separate benefit plan will not be available.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and BCBSND 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 the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, 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 Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within 31 days of the date of birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to BCBSND within 31 days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

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 a membership application within 31 days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

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 a membership application within 31 days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

5. If any of the Subscriber's children beyond the age of 26 are medically certified as mentally retarded or physically disabled, the Subscriber may continue their coverage under Family Coverage. 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. BCBSND 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. Medical qualification will be required.

6. If a child is no longer an Eligible Dependent under this Benefit Plan, the child must apply within 31 days of the loss of eligibility to be eligible for continuous health coverage under a separate benefit plan. See Section 5.9.

7. At the time of birth or adoption, Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to BCBSND within 31 days of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision and the Eligible Dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied.

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 of the month 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 membership application is not received in accordance with this provision and the employee or dependent is a Late Enrollee, the Late Enrollee's Waiting Period for Preexisting Conditions will be applied and 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.

5.9 CONTINUATION AND CONVERSION

A. Blue Cross Blue Shield Transfers

1. Inside the BCBSND Service Area

If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet BCBSND'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:

a. 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 BCBSND and the Plan Administrator has enrolled with another insurance carrier.

b. The Plan Administrator no longer meets BCBSND's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.

c. 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.

d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under group membership as provided in Section 5.9 (A.)(1.)(c.). 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 nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

2. Outside the BCBSND Service Area

If a Member moves to the service area of another Blue Cross Blue Shield Plan and BCBSND premiums are billed to the new address, membership must be transferred to the Blue Cross Blue Shield Plan serving that new address. The new Blue Cross Blue Shield Plan must at least offer the Subscriber its conversion benefit plan. Conversion benefit plans provide coverage without medical qualification. If the Member accepts the conversion benefit plan, the new Blue Cross Blue Shield Plan will credit the Member for days of continuous membership with BCBSND toward the Waiting Periods of the conversion benefit plan. Any physical or mental conditions covered by this Benefit Plan will be covered by the conversion benefit plan without a new Waiting Period if the Blue Cross Blue Shield Plan offers that feature to other members carrying the same type of coverage. The premium rate and benefits available through the conversion benefit plan of the Blue Cross Blue Shield Plan may vary significantly from those offered by BCBSND.

B. 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.

Medical qualification is not required for a Subscriber to choose continuation of coverage. However, under the law a Subscriber may have to pay all or part of the premium for continuation coverage. The law also says that during the 180-day period ending on the expiration of the 18, 29 or 36-month continuation period, a Subscriber or Eligible Dependent who has chosen continuation coverage may be provided with the option of enrollment under a conversion health plan otherwise generally available under this Benefit Plan. A membership application must be submitted within 31 days to be eligible for conversion coverage. If a membership application is not submitted within the 31-day period, medical qualification will be required.

Conversion Privileges

When the 18 or 36-month continuation period has ended, the Subscriber will be given the opportunity of enrolling under a conversion health plan.

If ineligibility occurs because of a failure to make timely payment for health care coverage, the Subscriber will be given the opportunity of enrolling under a conversion health plan if application is made within 60 days of ineligibility.

Contact BCBSND's NDPERS Service Unit at 1-800-223-1704 with any questions or for further information on conversion privileges.

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

BCBSND generally may not, under state law (Section 26.1-36-09.8, N.D.C.C.), 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, state 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, BCBSND may not, under state law, require that a Health Care Provider obtain authorization from BCBSND 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, BCBSND 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 BCBSND 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 managed benefits provisions that are not approved by BCBSND 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. BCBSND only has the authority 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 BCBSND'S RIGHT TO RECOVERY OF PAYMENT

All Members expressly consent and agree to reimburse BCBSND 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 BCBSND. Further, at the option of BCBSND, 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 BCBSND, 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 BCBSND under this Benefit Plan is confidential. Any PHI about a Member under this Benefit Plan obtained by BCBSND 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, BCBSND may disclose PHI to the Health Care Data Committee for the enhancement of price competition in the health care market. BCBSND 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 BCBSND in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for BCBSND 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 BCBSND 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 BCBSND to the insurance commissioner for access to records of BCBSND for purposes of enforcement or other activities related to compliance with state or federal laws.

5.15 PRIVACY OF PROTECTED HEALTH INFORMATION

BCBSND 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.

BCBSND 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. BCBSND 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. BCBSND 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

BCBSND maintains a Notice of Privacy Practices. This Notice of Privacy Practices outlines BCBSND's uses and disclosures of PHI, sets forth BCBSND'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 BCBSND 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 BCBSND on behalf of this Benefit Plan. Another portion of these retrospective discount payments, if offered, is paid to BCBSND. In its sole discretion, and only in the case where a Member is required to pay Coinsurance as part of the Cost Sharing Amounts for each Prescription Medication and Drug provided under the terms of this Benefit Plan, BCBSND may periodically refund to Members a proportional amount of any retrospective discount payments received. The calculation and payment of any such proportional refund rests in the sole discretion of BCBSND. The manner in which such retrospective discount program payment refund, if any, is distributed to a Member rests in the sole discretion of BCBSND. The Member waives any right, title, or interest in and to such proportional retrospective discount payment once the Member is no longer eligible for benefits under the terms of this Benefit Plan, and BCBSND may use its discretion and disburse any such retrospective discount payments as it deems appropriate and necessary in its administration of this Benefit Plan. The Member shall pay all Cost Sharing Amounts at the time the Prescription Medication or Drug is provided, without regard to any potential retrospective discount.

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.

5.19 CERTIFICATE OF CREDITABLE COVERAGE

A Member covered under this Benefit Plan may obtain a Certificate of Creditable Coverage by contacting BCBSND at the telephone number and address on the back of the Identification Card. A Certificate of Creditable Coverage will be provided to the Member within 31 days of this request.

When coverage under this Benefit Plan is terminated, BCBSND will, within 31 days, issue a Certificate of Creditable Coverage to the Subscriber. Upon notification by the Subscriber of the ineligibility of a dependent, a Certificate of Creditable Coverage will be issued to the affected Member within 31 days.

SECTION 6
CLAIMS FOR BENEFITS AND APPEALS

A Member may submit a Claim for Benefits by contacting BCBSND at the telephone number or address listed on the back of the Identification Card. The Member is responsible for providing BCBSND 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 BCBSND 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, Managed Benefits.

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 Claims 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) Extensions	72 Hours NONE	15 Days 15 Days	30 Days 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) Extensions	72 Hours NONE	30 Days NONE	60 Days NONE	As appropriate to the type of claim.

*If claim is made at least 24 hours before expiration of treatment and the claim involves an urgent care claim, BCBSND's decision must be made within 24 hours of receipt of the claim.

6.1 CLAIMS FOR BENEFITS INVOLVING PREAUTHORIZATION AND PRIOR APPROVAL (PRESERVICE CLAIMS FOR BENEFITS)

A. Claims for Benefits Requiring Preauthorization or Prior Approval.

1. <u>Claims for Benefits Requiring Preauthorization or Prior Approval</u>. 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, BCBSND 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. BCBSND may extend this initial time period an additional 15 days if BCBSND 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, BCBSND 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. BCBSND 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, BCBSND 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. <u>Claims for Benefits Involving an Ongoing Course of Treatment or Number of Treatments</u>. For services or benefits involving an ongoing course of treatment taking place over a period of time or number of treatments, BCBSND 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, BCBSND 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. <u>Appeals of Claims for Benefits Requiring Preauthorization and Prior Approval</u>. The Member and/or the Member's Authorized Representative have up to 180 days to appeal BCBSND's benefit determination of a Claim for Benefits requiring Preauthorization or Prior Approval benefits or services. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND 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. <u>Claims for Benefits for Emergency Services</u>. Upon receipt of a Claim for Benefits for Emergency Services from a Member and/or a Member's Authorized Representative, BCBSND 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 BCBSND requests additional or specified information, BCBSND 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 BCBSND 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, BCBSND 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 BCBSND 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 BCBSND'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, BCBSND 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 BCBSND 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, BCBSND 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. BCBSND may extend this initial time period in reviewing a Claim for Benefits an additional 15 days if BCBSND 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.

BCBSND 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, BCBSND 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, BCBSND 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, BCBSND 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 BCBSND's benefit determination of a Claim for Benefits. Upon receipt of an appeal from a Member and/or a Member's Authorized Representative, BCBSND 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.

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.

SECTION 7
OTHER PARTY LIABILITY

This section describes BCBSND'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. BCBSND 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; medical benefits under group or individual automobile contracts; 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; 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 BCBSND 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 BCBSND 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. BCBSND may obtain the facts it needs from or give them to other organizations or persons for the purpose of administering this provision. BCBSND need not tell, or obtain the consent of, any person to do this. Each Member claiming benefits under this Benefit Plan must provide BCBSND 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, BCBSND 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. BCBSND will not have to pay that amount again.

RIGHT OF RECOVERY

If payments have been made by BCBSND for Covered Services in excess of the amount payable under this Benefit Plan, BCBSND 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 BCBSND to recover excess payments.

This provision is administered in accordance with the Coordination of Benefits Regulation adopted by the North Dakota Insurance Commissioner.

7.2 AUTOMOBILE NO-FAULT OR MEDICAL PAYMENT BENEFIT COORDINATION

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 and coordinated with 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 BCBSND 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, BCBSND shall have certain rights of assignment, subrogation and/or reimbursement as set forth below. BCBSND has full discretionary authority to determine whether to exercise any or all of said rights.

A Member must notify BCBSND of the circumstances of the injury or condition, cooperate with BCBSND in doing whatever is necessary to enable BCBSND to assert these rights, and do nothing to prejudice them. The rights stated herein apply automatically in any applicable situation. BCBSND has no obligation to notify a Member of BCBSND's intent to exercise one or more of these rights and BCBSND'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 BCBSND to assignment, subrogation or reimbursement, BCBSND 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.

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), BCBSND 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 BCBSND of said recovery and must reimburse BCBSND to the full extent of any benefits paid by BCBSND, 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 BCBSND until BCBSND has been fully reimbursed.

The Member agrees to not transfer any right to any recovery to a third party or otherwise attempt to avoid BCBSND's rights under this Benefit Plan. The Member agrees that any recovery shall be held in trust for BCBSND until BCBSND has been fully reimbursed and/or that BCBSND 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, BCBSND 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 BCBSND of the circumstances of the injury and condition, cooperate with BCBSND 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, BCBSND 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. BCBSND shall determine the interpretation and application of the Definitions in each and every situation.

8.1 **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.

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

8.3 **AMBULATORY BEHAVIORAL HEALTH CARE** - the continuum of services provided for substance abuse and psychiatric illness less intensive than inpatient and more intensive than outpatient treatment. This continuum includes those services referred to as Partial Hospitalization or intensive outpatient treatment as long as the treatment meets or exceeds the minimum required for Partial Hospitalization.

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

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

8.6 **ANNUAL ENROLLMENT PERIOD** - a period of time an eligible employee or Eligible Dependent may apply for coverage under this Benefit Plan as a Late Enrollee. The Annual Enrollment Period will be determined by the Plan Administrator.

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

8.8 **BASIC PLAN** - the Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level.

8.9 **BCBSND** - Blue Cross Blue Shield of North Dakota, a legal trade name of Noridian Mutual Insurance Company.

8.10 **BENEFIT PERIOD** - a specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits 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.

8.11 **BENEFIT PLAN** - the agreement with BCBSND, Including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments.

8.12 **BENEFIT PLAN ATTACHMENT** - the statement accompanying the Identification Card that identifies current Benefit Plan information.

8.13 **BENEFIT PLAN NUMBER** - a number assigned by BCBSND and listed on the Identification Card that identifies the Subscriber for administrative purposes.

8.14 **BLUECARD PROGRAM** - The Blue Cross and Blue Shield Association, of which BCBSND is an independent licensee, has implemented the BlueCard Program. This allows Members seeking medical services outside BCBSND'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.

8.15 **CLAIM FOR BENEFITS** - a request for a benefit or benefits under the terms of this Benefit Plan made by a Member in accordance with BCBSND's reasonable procedures for filing a Claim for Benefits as outlined in Section 6, Claims for Benefits and Appeals. A Claim for Benefits includes both Claims for Benefits requiring Preauthorization and Prior Approval (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.

8.16 **CLASS OF COVERAGE** - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage are as follows:

A. **Single Coverage** - Subscriber only.

B. **Family Coverage** - Subscriber and Eligible Dependents.

8.17 **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 and Deductible Amounts. Applicable Cost Sharing Amounts are identified on the Benefit Plan Attachment. Health Care Providers may bill you directly or request payment of Coinsurance 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.

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

If Covered Services are obtained by a Member out of the BCBSND 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 BCBSND 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 BCBSND prior to incurring out-of-area services, BCBSND 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. **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.

The Deductible Amounts for Covered Services received from a PPO Health Care Provider or on a Basic Plan basis accumulate jointly up to the PPO Deductible Amount.

D. **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. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.

The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider or on a Basic Plan basis accumulate jointly up to the PPO Out-of-Pocket Maximum Amount. When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.

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

8.19 **CUSTODIAL CARE** - care that BCBSND 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.

8.20 **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.

8.21 **ELIGIBLE DEPENDENT** - a dependent of the Subscriber 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 between persons of the opposite sex.

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) both the parent and the grandchild are 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 mental retardation 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 BCBSND of these disabilities.

8.22 **EMERGENCY MEDICAL CONDITION** - a medical condition of recent onset and severity, including severe pain, 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.

8.23 **EMERGENCY SERVICES** - health care services, supplies or treatments furnished or required to screen, evaluate and treat an Emergency Medical Condition.

8.24 **ENROLLMENT DATE** - the first day of coverage or, if there is a Probation Period, the first day of the Probation Period.

8.25 **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. BCBSND 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. BCBSND 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. BCBSND 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.

8.26 **EXPLANATION OF BENEFITS** - a document sent to the Member by BCBSND 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.

8.27 **GROUP** - NDPERS has signed an agreement with BCBSND to provide health care benefits for its eligible employees and Eligible Dependents, see definition 8.21.

8.28 **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, Nurse Practitioner or Psychiatric Nurse.

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

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

H. **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.

I. **Home Infusion Therapy Provider**.

J. **Home Medical Equipment Supplier**.

K. **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.

L. **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.

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

N. **Licensed Addiction Counselor**.

O. **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.

P. **Licensed Independent Clinical Social Worker** - an individual who has a doctorate or master's degree in social work from a college or university and who has fulfilled the requirements for licensure or has been registered by the North Dakota Board of Social Work Examiners for third party reimbursement before August 1, 1997.

Q. **Licensed Professional Clinical Counselor**.

R. **Licensed Registered Dietitian**.

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

T. **Mobile Radiology Supplier**.

U. **Occupational Therapist**.

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

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

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

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

Z. **Pharmacist**.

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

BB. **Physical Therapist**.

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

DD. **Physician Assistant**.

EE. **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.).

FF. **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.

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

HH. **Residential Treatment Center**.

II. **Respiratory Therapist**.

JJ. **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.

KK. **Sleep Lab**.

LL. **Speech Therapist**.

MM. **Substance Abuse Facility** - an institution or a distinct part of an institution providing medically monitored inpatient detoxification delivered by nursing or medical professionals or rehabilitation treatment for alcohol or other drug abuse.

NN. **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.

8.29 **HOME HEALTH CARE** - Skilled Nursing Services provided under active Physician and nursing management through a central administrative unit coordinated by a registered nurse. Benefit eligibility requires that the Member's medical condition must be such that, without the availability of Skilled Nursing Services, the Member would require inpatient care.

8.30 **HOME HEALTH VISIT** - the provision of skilled nursing and other therapeutic services up to a maximum of 8 hours per day to a Member confined to their home.

8.31 **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.

8.32 **IDENTIFICATION CARD** - a card issued in the Subscriber's name identifying the Benefit Plan Number. 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.

8.33 **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.

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

8.35 **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.

8.36 **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.

8.37 **LATE ENROLLEE** - an eligible employee or Eligible Dependent who requests enrollment under this Benefit Plan after the initial enrollment period when the individual was entitled to enroll under the terms of this Benefit Plan and applies for coverage during the Annual Enrollment Period. However, an eligible employee or Eligible Dependent may not be considered a Late Enrollee if:

A. The individual:

1. was covered under Qualifying Previous Coverage at the time of the initial enrollment;
2. lost coverage under Qualifying Previous Coverage as a result of termination of employment or eligibility, the involuntary termination of the Qualifying Previous Coverage, death of a spouse or divorce; and
3. requests enrollment within 31 days after termination of the Qualifying Previous Coverage.

B. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

C. A court has ordered coverage be provided for a spouse or minor or dependent child under the eligible employee's Benefit Plan and the request for enrollment is made within 30 days after issuance of the court order.

D. The individual had coverage under a Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82] continuation provision and the coverage under that provision was exhausted.

8.38 **LIFETIME MAXIMUM** - the total dollar amount of certain Covered Services an eligible Member may receive during a lifetime while enrolled under a Benefit Plan sponsored by the Group. The benefit amounts paid under all previous Benefit Plans sponsored by the Group will be applied toward the Lifetime Maximum for such Covered Services under this Benefit Plan.

8.39 **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.

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

8.41 **MEDICAL DIRECTOR** - the Physician designated by BCBSND and the Network to oversee and direct all matters pertaining to the management of the benefits for medical care and treatment.

8.42 **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 BCBSND:

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.

8.43 **MEMBER** - the Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents.

8.44 **NONPARTICIPATING HEALTH CARE PROVIDER** - a Health Care Provider that does not have a participation agreement with BCBSND.

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

8.46 **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.

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

8.48 **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.

8.49 **PARTIAL HOSPITALIZATION** - continuous treatment of mental illness or substance abuse by a Health Care Provider for at least 3 hours, but not more than 12 hours in any 24-hour period. Preauthorization is required.

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

8.51 **PARTICIPATING PHARMACY** - a Pharmacy that has entered into an agreement with BCBSND's Preferred Pharmacy Network.

8.52 **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").

8.53 **PREAUTHORIZATION** - the process of the Member or the Member's representative notifying BCBSND to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions of Section 3.2. Preauthorization does not guarantee payment of benefits.

8.54 **PREEXISTING CONDITION** - a condition, disease, illness or injury for which the Member received medical advice or treatment within the 6-month period immediately preceding the Member's Enrollment Date under this Benefit Plan. Pregnancy is not considered a Preexisting Condition.

8.55 **PRESCRIPTION MEDICATION OR DRUG** - any legend drug, Payable Over-the-Counter 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 a safe, therapeutically effective, high quality and cost effective drug 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 BCBSND 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 BCBSND when dispensed by a Pharmacist upon the receipt of a Prescription Order.

G. **Restricted Use Drug** - a Prescription Medication or Drug that may require Prior Approval and/or be subject to a limited dispensing amount.

8.56 **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.

8.57 **PRIOR APPROVAL** - the process of the Member or Member's representative providing information to BCBSND substantiating the medical appropriateness of specified services to BCBSND in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. BCBSND reserves the right to deny benefits if Prior Approval is not obtained.

8.58 **PROBATION PERIOD** - the period that must pass before an employee or dependent is eligible for coverage in a group health plan.

8.59 **PROFESSIONAL HEALTH CARE PROVIDER** - an Advanced Practice Registered Nurse, Ambulatory Surgical Facility, Audiologist, Certified Diabetes Educator, Chiropractor, Dentist, Home Infusion Therapy Provider, Independent Clinical Laboratory, Licensed Addiction Counselor, Licensed Clinical Psychologist, Licensed Independent Clinical Social Worker, Licensed Professional Clinical 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.

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

8.61 **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.

8.62 **QUALIFYING PREVIOUS COVERAGE** - with respect to an individual, health benefits or coverage provided under any of the following:

A. A group health benefit plan;
B. A health benefit plan;
C. Medicare;
D. Medicaid;
E. TRICARE (the health care program for military dependents and retirees);
F. A medical care program of the Indian health service or of a tribal organization;
G. A state health benefit risk pool, including coverage issued under N.D. Cent. Code §26.1-08;
H. A health plan offered under §5 U.S.C. 89;
I. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government or a foreign government;
J. A health benefit plan under §5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
K. A state children's health insurance program (SCHIP).

Qualifying Previous Coverage must be continuous until at least 63 days prior to the individual Member's Enrollment Date under this Benefit Plan.

8.63 **RESIDENTIAL TREATMENT** - a 24 hour a day program 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. The residential treatment center must be licensed by the state of North Dakota. If the residential treatment center is located outside the state of North Dakota, it must meet the North Dakota licensure requirements. Preauthorization is required.

8.64 **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.

8.65 **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.

8.66 **SUBSCRIBER** - an employee whose application for membership has been accepted, whose coverage is in force with BCBSND and in whose name the Identification Card and Benefit Plan Attachment are 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.

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

8.68 **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 the approval granted by the U.S. Food and Drug Administration and/or listed as an accepted unlabeled use by the current edition of the USPDI Drug Information for the Health Care Professional and is determined by BCBSND to have been administered in accordance with 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. **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.

D. **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.

E. **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.

F. **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.

G. **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.