North Dakota Medicaid Expansion Benefit Plan

Certificate of Insurance

KEEP THIS DOCUMENT IN A SAFE PLACE.

In accordance with Medicaid regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate against any member on the basis of race; ethnicity; color; national origin; disability; sex; gender; gender identity; sexual orientation; religion; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; sources of payment for care; existence of an Advance Directive or age, in admission, treatment, or participation in its programs, services, and activities.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at (1-833-777-5779) (toll-free) or through the North Dakota Relay at (1-800-366-6888) or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race; ethnicity; color; national origin; disability; sex; gender; gender identity; sexual orientation; religion; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; sources of payment for care; existence of an Advance Directive or age, in admission, treatment, or participation in its programs, services, and activities, you can file a grievance with:

Civil Rights Coordinator

4510 13th Ave S

Fargo, ND 58121

(701-297-1638) or North Dakota Relay at (800-366-6888) or 711

(701-282-1804) (fax)

CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email. Grievance forms are available at www.medicaid.bcbsnd.com or by calling (1-833-777-5779). If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW.

Room 509F, HHH Building

Washington, DC 20201

800-368-1019 or 800-537-7697 (TDD)

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

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al (1-833-777-5779) (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (1-833-777-5779) (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (1-833-777-5779)（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (1-833-777-5779) (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (1-833-777-5779) (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (1-833-777-5779) (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (1-833-777-5779) (رقم هاتف الصم والبكم:
1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu (1-833-777-5779) (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (1-833-777-5779) (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(1-833-777-5779)（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (1-833-777-5779) (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (1-833-777-5779) (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (1-833-777-5779) (TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (1-833-777-5779) (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring (1-833-777-5779) (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti’go **Diné Bizaad**, saad bee áká’ánída’áwo’dęę’, t’áá jiik’eh, éí ná hóló, kojį’ hódíílnih (1-833-777-5779) (TTY: 1-800-366-6888 éí doodagó 711.)

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
HEALTH BENEFIT PLAN

In consideration of the acceptance of your application for coverage under the North Dakota Medicaid Expansion Program, Blue Cross Blue Shield of North Dakota (BCBSND), through an agreement with the North Dakota Department of Health & Human Services, for administration of the North Dakota Medicaid Expansion Program, enters into this legal agreement with you, the Member. This legal agreement includes this Benefit Plan, your application, Identification Card and any endorsements, supplements, attachments, addenda or amendments. These documents describe the health benefits available to you, and the benefits described are available as long as you remain enrolled in the North Dakota Medicaid Expansion Program. No change in this legal agreement is valid unless approved by BCBSND and the North Dakota Department of Health & Human Services. Changes to provisions in this Benefit Plan will be sent to the Member.

The Member 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 Member further acknowledges and agrees this legal agreement 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 Member for any of BCBSND's obligations to the Member created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this agreement.

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

Daniel Conrad
Its President and CEO

MEMBER SERVICES

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

1-833-777-5779

Office Address and Hours:

You may visit our Home Office during normal business hours –

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

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

Mailing Address:

You may write to us at the following address –

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

Internet Address:

medicaid.bcbsnd.com

Nurse Call Line

The Nurse Call Line is available 24 hours a day, 7 days a week and will connect you with a nurse who can help answer your health questions including the kind of care you need and whether a health concern requires urgent or emergency care. Interpreter Services are available for people who do not speak English.

Call 1-833-777-5779

Behavioral Health Crisis Line

The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week and will connect you with a professional who will provide support and counseling.

Call 1-833-777-5779

Offices:

We invite you call Member Services at 1-833-777-5779 or contact the Office closest to you –

Fargo Office
4510 13th Avenue South

Jamestown Office
300 2nd Avenue Northeast
Suite 132

Bismarck Office
1415 Mapleton Avenue

Grand Forks Office
3570 South 42nd Street, Suite B

Minot Office
1308 20th Avenue Southwest

Williston Office
1500 14th Street West, Suite 270

Provider Directories:

Members can obtain a Provider Directory or a list of Network Providers by calling the telephone number 1-833-777-5779 or by visiting the BCBSND Medicaid Expansion website at medicaid.bcbsnd.com.

Prescription Drugs

Retail outpatient pharmacy benefits are administered by the North Dakota Department of Health & Human Services and not by BCBSND. You will have a different identification card from the North Dakota Department of Health & Human Services for use when filling outpatient prescriptions. If you have questions about your Pharmacy benefits, please call the North Dakota Department of Health & Human Services at 1-800-755-2604 I TTY:711.

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INTRODUCTION

Benefits described in this Benefit Plan are available to Members and cannot be transferred or assigned.

The Member will receive an Identification Card displaying the Unique Member Identifier and other information about this Benefit Plan. Carry the Identification Card at all times. If the Identification Card is lost, contact BCBSND to request a replacement.

Allowing another individual to use your Identification Card is prohibited. If you do so, you will be investigated by the fraud and abuse unit of North Dakota Department of Health & Human Services which could lead to civil or criminal sanctions and termination of coverage.

Present your Identification Card to your Health Care Provider to identify yourself as a Member. 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 the services or you did not receive the services.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member you have the right to:

- Receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sexual orientation or sex.
- Be treated respectfully and with consideration for your personal dignity and privacy.
- Privacy of your personal health information that BCBSND maintains in accordance with federal and state laws.
- Request and receive a copy of your medical records in the possession of BCBSND and request that they be amended or corrected in accordance with the federal law.
- Be informed about your health condition and to receive information regarding available treatment options and alternatives, in a manner appropriate to your condition and ability to understand, regardless of cost or benefit coverage.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Make recommendations regarding this Member rights and responsibilities statement.
- Use the Grievance and appeal process for complaints, comments and timely resolution of disputes. You may do so by contacting BCBSND Member Services at the telephone number on the back of your Identification Card.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Be free to exercise all rights and that by exercising those rights, you shall not be adversely treated by the North Dakota Department of Health & Human Services, BCBSND or its Network Providers.
- Receive information about BCBSND, its products and services, its Network Providers and your rights and responsibilities, in accordance with 42 CFR §438.10.
- Request assistance with effective communication including written information in other formats and written and oral translation services.

As a Member you have the responsibility to:

- Know your health plan benefits and the requirements for accessing and receiving benefits under this Benefit Plan.
- Notify the North Dakota Department of Health & Human Services within 10 days at toll-free (844) 854-4825|ND Relay TTY: (800) 366-6888 (toll-free) if you change your name, address or telephone number.
- Notify the North Dakota Department of Health & Human Services of any changes of eligibility that may affect your membership or access to services.
- Provide the necessary information to your Health Care Providers to determine appropriate care.
- Follow the treatment plan prescribed by your Health Care Provider.
- Timely provide BCBSND the necessary information to process your claims and provide you with the benefits available to you under 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 LIFETIME MAXIMUM

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

1.2 SELECTING A HEALTH CARE PROVIDER

At the time of enrollment, the Member will have a Primary Care Provider (PCP) assigned. The PCP provides and manages the Member's care, and also assists in coordinating the Member's care with specialists and other Health Care Providers. The PCP is the Member's point of access for preventive care or an illness and may treat the Member directly, refer the Member to a specialist, or admit the Member to a Hospital. The Member can request to change their PCP by finding another PCP using the North Dakota Medicaid Expansion directory of Network Providers at medicaid.bcbsnd.com or by contacting Member Services at the toll-free number listed on the back of the Identification Card.

All services must be obtained from a Network Provider to be eligible for payment as a Covered Service. Services received from an Out-of-Network Provider will not be covered unless one of the following exceptions exists:

- Emergency Services;
- Family Planning Services;
- Women’s routine and preventive health care services;
- New Members who receive Covered Services the first 30 days after enrolling in Medicaid Expansion;
- Maternity Services; or
- An Authorized Referral is obtained from BCBSND when access to a Network Provider is not available or feasible.

When a Member receives Covered Services from a Network Provider or an Out-of-Network Provider who agrees to accept BCBSND's Allowance and is enrolled with the North Dakota Department of Health & Human Services, the Health Care Provider will submit claims to BCBSND on behalf of the Member, and BCBSND will pay the Health Care Provider directly. These Network and Out-of-Network Providers agree to accept BCBSND's Allowance as full and final payment from BCBSND and are not allowed to balance bill the Member for any remaining charge. If the Member receives services not covered under the Benefit Plan, the Health Care Provider may bill the Member for the entire cost of the service if the Member is given advance notice prior to receiving the service.

Health Care Providers must file claims to BCBSND within 180 days after the date that the Covered Service was incurred.

There is no coverage for services received outside the United States.

This Benefit Plan does not include Out-of-Network Provider coverage unless one of the limited exceptions applies. If a Member chooses to receive Covered Services from an Out-of-Network Provider without an available exception, the Member may be responsible for all financial charges from that Out-of-Network Provider.

1.3 AUTHORIZED REFERRAL PROCESS

Benefits for services received from an Out-of-Network Provider as a result of an Authorized Referral will be covered at the Network Provider level, subject to the conditions, limitations and exclusions of this Benefit Plan. Benefit payment will be denied if a Member seeks services from an Out-of-Network Provider without an Authorized Referral.

A Network Provider is responsible for notifying BCBSND of an Authorized Referral.

Members are responsible to confirm with the Network Provider that an Authorized Referral has been obtained from BCBSND.

1.4 CONTINUITY OF CARE

If a Member is receiving an active course of treatment care from a Network Provider who becomes an Out-of-Network Provider during the active course of treatment, BCBSND will authorize continuity of care at the Network Provider level for the following conditions or situations:

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

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

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

The Member or the Member's Authorized Representative must submit a written request for continuity of care to BCBSND within 180 days of the first day the Health Care Provider is deemed an Out-of-Network Provider.

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

1.5 OUTLINE OF COVERED SERVICES

The benefit amounts specified in this outline apply only to Covered Services received from Network Providers, except as specifically allowed in Section 1.2, Selecting a Health Care Provider. For a description of Covered Services, see Section 2 Covered Services.

	Provider of Service:	
Covered Services	**Network**	**Out-of-Network**
Inpatient Hospital and Medical Services		
• Inpatient Hospital Services	100% of Allowed Charge.	**No Coverage.**
• Inpatient Medical Care Visits	100% of Allowed Charge.	**No Coverage.**
• Transitional Care Unit Services	100% of Allowed Charge.	**No Coverage.**
• Ancillary Services	100% of Allowed Charge.	**No Coverage.**
• Inpatient Consultations	100% of Allowed Charge.	**No Coverage.**
• Concurrent Services	100% of Allowed Charge.	**No Coverage.**
Inpatient and Outpatient Surgical Services		
• Professional Health Care Provider Services	100% of Allowed Charge.	**No Coverage.**
• Assistant Surgeon Services	100% of Allowed Charge.	**No Coverage.**
• Ambulatory Surgical Facility Services	100% of Allowed Charge.	**No Coverage.**
• Hospital Ancillary Services	100% of Allowed Charge.	**No Coverage.**
• Anesthesia Services	100% of Allowed Charge.	**No Coverage.**
• Bariatric Surgery	100% of Allowed Charge. Benefits are subject to a Lifetime Maximum of 1 operative procedure per Member when Precertification is received from BCBSND. Psychiatric and substance use services are excluded from the Lifetime Maximum. Covered Services must be received from a surgical facility approved by BCBSND.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
Transplant Services		
• Inpatient and Outpatient Hospital and Medical Services	100% of Allowed Charge when Precertification is received from BCBSND. Covered Services must be received from a transplant facility approved by BCBSND.	**No Coverage.**
Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment	100% of Allowed Charge. Benefits are subject to a Lifetime Maximum of 2 surgical procedures per Member and a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.	**No Coverage.**
Outpatient Hospital and Medical Services		
• Home and Office Visits	100% of Allowed Charge.	**No Coverage.**
• Diagnostic Services	100% of Allowed Charge.	**No Coverage.**
• Emergency Services (See Section 8, Definitions)	100% of Allowed Charge.	100% of Allowed Charge.
• Urgent Care Services at Urgent Care Center or Facility	100% of Allowed Charge.	**No Coverage.**
• Dental Services		
Accidental Injury	100% of Allowed Charge.	**No Coverage.**
Dental Anesthesia and Hospitalization	100% of Allowed Charge. Precertification is required.	**No Coverage.**
Periodontal Disease Services	100% of Allowed Charge.	**No Coverage.**
• Second Opinions		
Diagnostic Services	100% of Allowed Charge.	**No Coverage.**
Related Office Visit	100% of Allowed Charge.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
• Radiation Therapy and Chemotherapy	100% of Allowed Charge.	**No Coverage.**
• Positron Emission Tomography (PET) Scan with a Prostate Cancer Diagnosis	100% of Allowed Charge.	**No Coverage.**
• Dialysis Treatment	100% of Allowed Charge.	**No Coverage.**
• Home Infusion Therapy Services	100% of Allowed Charge.	**No Coverage.**
• Allergy Services	100% of Allowed Charge.	**No Coverage.**
• Phenylketonuria (PKU) - Foods and food products for the dietary treatment of Members born after 12/31/62 with phenylketonuria	100% of Allowed Charge.	**No Coverage.**
• Amino Acid-Based Elemental Oral Formulas	100% of Allowed Charge.	**No Coverage.**
Wellness Services		
• Preventive Screening Services		
Routine Physical Examination (Office Visit)	100% of Allowed Charge.	**No Coverage.**
• Immunizations	100% of Allowed Charge. 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.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
Routine Diagnostic Screenings: ➢ Lipid Disorders Screening once every 5 years ➢ Osteoporosis Screening for female Members once every 2 years ➢ Sexually Transmitted Disease (STD) Screening ➢ Diabetes Screening ➢ Hepatitis C Virus (HCV) Screening ➢ Lung Cancer Screening for Members age 50 and older with a 20 pack per year smoking history ➢ Hepatitis B Virus (HBV) Screening for Members at high risk ➢ Tuberculosis Screening	100% of Allowed Charge.	**No Coverage.**
Breast Cancer Screening		
Mammography with or without Digital Breast Tomosynthesis Screening (3D Mammography)	100% of Allowed Charge. • One service for Members between the ages of 35 and 40; • One service per year for Members age 40 and older.	**No Coverage.**
Cervical Cancer Screening	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.	**No Coverage.**
Related Office Visit	100% of Allowed Charge.	**No Coverage.**
Colorectal Cancer Screening for Members age 45 and older		
➢ Fecal Occult Blood Testing (FOBT), Fecal Immunochemical Tests (FIT) – subject to a Maximum Benefit Allowance of 1 test per Benefit Period; and	100% of Allowed Charge.	**No Coverage.**
➢ FIT DNA – subject to a Maximum Benefit Allowance of 1 test every 3 years; or	100% of Allowed Charge.	**No Coverage.**
➢ Colonoscopy – subject to a Maximum Benefit Allowance of 1 test every 10 years; or	100% of Allowed Charge.	**No Coverage.**
➢ CT Colonography – subject to a Maximum Benefit Allowance of 1 test every 5 years; or	100% of Allowed Charge.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
➢ Sigmoidoscopy – subject to a Maximum Benefit Allowance of 1 test every 5 years.	100% of Allowed Charge.	**No Coverage.**
Prostate Cancer Screening for Members age 40 and older	100% of Allowed Charge.	**No Coverage.**
Related Office Visit	100% of Allowed Charge.	**No Coverage.**
Intensive Behavioral Interventions for Obesity	100% of Allowed Charge. Benefits are subject to Maximum Benefit Allowances of 26 visits per Member per Benefit Period.	**No Coverage.**
Nutritional Counseling	100% of Allowed Charge. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance. • Hyperlipidemia – Maximum Benefit Allowance of 12 visits per Member per Benefit Period. • Gestational Diabetes – Maximum Benefit Allowance of 12 visits per Member per Benefit Period. • Diabetes Mellitus – Maximum Benefit Allowance of 12 visits per Member per Benefit Period. • Hypertension – Maximum Benefit Allowance of 12 visits per Member per Benefit Period. • Other diabetes related diagnosis or a chronic illness or condition – Maximum Benefit Allowance of 12 visits per Member per Benefit Period.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
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.		
• Outpatient Nutritional Care Services (Including Feeding and Eating Disorders)	100% of Allowed Charge. Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical condition. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance. PKU – Maximum Benefit Allowance of 12 Office Visits per Member per Benefit Period.	**No Coverage.**
• Diabetes Education Services	100% of Allowed Charge.	**No Coverage.**
• Diabetes Prevention Program	100% of Allowed Charge.	**No Coverage.**
• Comprehensive Eye Examination with Dilation for Medical Conditions	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.	**No Coverage.**
• Tobacco Cessation Counseling Services	100% of Allowed Charge.	**No Coverage.**
Outpatient Therapy Services		
• Rehabilitative Therapy		
Physical Therapy	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Occupational Therapy	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Speech Therapy	100% of Allowed Charge.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
	Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	
• Habilitative Therapy		
Physical Therapy	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Occupational Therapy	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Speech Therapy	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 visits per Member per Benefit Period. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
• Other Therapy Services		
Respiratory Therapy Services	100% of Allowed Charge.	**No Coverage.**
Cardiac Rehabilitation Services	100% of Allowed Charge.	**No Coverage.**
Pulmonary Rehabilitation Services	100% of Allowed Charge.	**No Coverage.**
Vision Therapy	100% of Allowed Charge.	**No Coverage.**
Chiropractic Services	Benefits are subject to a Maximum Benefit Allowance of 20 visits per Member per Benefit Period.	

Covered Services	Provider of Service: Network	Out-of-Network
• Home and Office Visits	100% of Allowed Charge.	**No Coverage.**
• Therapy and Manipulations	100% of Allowed Charge.	**No Coverage.**
• Diagnostic Services	100% of Allowed Charge.	**No Coverage.**
Maternity Services		
• Inpatient Hospital and Medical Services	100% of Allowed Charge.	100% of Allowed Charge.
• Prenatal and Postnatal Care Services	100% of Allowed Charge.	100% of Allowed Charge.
Related Prenatal or Postnatal Office Visit	100% of Allowed Charge.	100% of Allowed Charge.
• Lactation Counseling	100% of Allowed Charge.	100% of Allowed Charge.
Family Planning Services	100% of Allowed Charge.	100% of Allowed Charge.
Contraceptive Services	100% of Allowed Charge.	100% of Allowed Charge.
• Related Office Visit	100% of Allowed Charge.	100% of Allowed Charge.
Psychiatric and Substance Use Services		
• Psychiatric Services		
Inpatient	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Residential Treatment	100% of Allowed Charge. Precertification is required.	**No Coverage.**
Partial Hospitalization	100% of Allowed Charge.	**No Coverage.**
Intensive Outpatient Program	100% of Allowed Charge.	**No Coverage.**
Outpatient		
Home and Office Visits Including assessment, counseling, Behavioral Modification Intervention for Autism Spectrum Disorder (Including Applied Behavioral Analysis (ABA)), treatment planning, coordination of care, psychotherapy and group therapy	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Outpatient Services Including diagnostic testing, diagnostic procedures and treatment procedures	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
• Substance Use Services		

Covered Services	Provider of Service: Network	Out-of-Network
Inpatient	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Residential Treatment	100% of Allowed Charge. Precertification is required.	**No Coverage.**
Partial Hospitalization	100% of Allowed Charge.	**No Coverage.**
Intensive Outpatient Program	100% of Allowed Charge.	**No Coverage.**
Outpatient		
Home and Office Visits Including assessment, counseling, treatment planning, coordination of care, psychotherapy and group therapy and Opioid Treatment Program	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Outpatient Services Including diagnostic testing, diagnostic procedures and treatment procedures	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Ambulance Services		
• Ground Ambulance	100% of Allowed Charge.	**No Coverage.**
• Air Ambulance	100% of Allowed Charge. Precertification may be required.	**No Coverage.**
Skilled Nursing Facility Services	100% of Allowed Charge. Benefits are subject to a Maximum Benefit Allowance of 30 days per Member per Benefit Period. Psychiatric and substance abuse services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Home Health Care Services	100% of Allowed Charge. Precertification is required. Psychiatric and substance use services are excluded from the Maximum Benefit Allowance.	**No Coverage.**
Hospice Services	100% of Allowed Charge.	**No Coverage.**
Private Duty Nursing Services	100% of Allowed Charge.	**No Coverage.**

Covered Services	Provider of Service: Network	Out-of-Network
Medical Supplies and Equipment • Home Medical Equipment • Orthotic Devices • Supplies for Administration of Prescription Medications • Oxygen Equipment and Supplies • Ostomy Supplies • Prosthetic Appliances and Limbs	100% of Allowed Charge.	**No Coverage.**
• Hearing Aids	Subject to a Maximum Benefit Allowance per Member of 1 hearing aid per ear every 3 years. Precertification is required.	
Breast Pumps	100% of Allowed Charge. Benefits are available for the rental or purchase of 1 breast pump per pregnancy.	**No Coverage.**
Telehealth	100% of Allowed Charge.	**No Coverage.**
Transportation Services	100% of Allowed Charge. Approval may be required.	**No Coverage.**

Note: All non-emergency transportation must receive approval from BCBSND at least 2 business days in advance of the scheduled appointment.

Meals and Lodging Services	100% of Allowed Charge. Approval is required.	**No Coverage.**

Note: Members must receive approval from BCBSND for Meals and lodging at least 2 business days in advance of the scheduled appointment. Benefits for meals and lodging is allowed only when medical services or transportation require a Member to be away overnight.

Outpatient Prescription Medications or Drugs

Retail outpatient pharmacy benefits are administered by the North Dakota Department of Health & Human Services and not by BCBSND. Members will have a different identification card from the North Dakota Department of Health & Human Services for use when filling outpatient prescriptions. Members should contact the North Dakota Department of Health & Human Services with questions about pharmacy benefits at 1-800-755-2604 I TTY:711.

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, Maximum Benefit Allowances and Lifetime Maximums described in the Schedule of Benefits.

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

2.1 INPATIENT HOSPITAL AND MEDICAL SERVICES

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

A. Inpatient Hospital Services include:

1. Bed, board and general nursing services.

2. Special Care Units when Medically Appropriate and Necessary.

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

4. Transitional Care Unit when Medically Appropriate and Necessary.

5. 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.

6. Dental anesthesia and hospitalization for dental care.

B. Inpatient Medical Services include:

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

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

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

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

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. 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 2.18, 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 disorder.

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

3. Bariatric surgery when Precertification is received from BCBSND. Covered Services must be received from a surgical facility approved by BCBSND. Benefits are subject to a Lifetime Maximum of 1 bariatric surgery per Member. Psychiatric and substance use services are excluded from the Lifetime Maximum. Guidelines and criteria are available upon request.

   Benefits for all proposed surgical procedures for the treatment of complications resulting from any or all types of bariatric surgery are available only when Precertification is received from 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. Covered Services must be received from a transplant facility approved by BCBSND. Precertification is required.

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

Please contact 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 all charges.

B. Covered Services include:

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

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

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

4. Compatibility testing services provided to the donor.

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

6. Transportation costs by air ambulance, commercial carrier or charter when a Member must be transported within a restricted time frame to obtain a covered transplant procedure.

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 and the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1.

2.5 OUTPATIENT HOSPITAL AND MEDICAL SERVICES

Outpatient Hospital and Medical Services include:

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

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

C. Emergency Services and after-hours care (24/7), including Post-Stabilization Care are available at any Hospital or medical facility, whether or not the facility is a Network Provider. Precertification is not required. In the event of a life-threatening situation or if an Ambulance is needed, please call 911.

D. Dental services provided by a Physician, Qualified Healthcare Practitioner (QHP), Oral Surgeon or Dentist (D.D.S.) in an office setting, including extractions done in preparation for Radiation treatment for neoplastic diseases involving the jaw, frenotomy, frenectomy, oral biopsy, oral lesion removal, oral abscess treatment or as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. Covered Services for the jaw, sound natural teeth, dentures, mouth or face as a result of an accidental injury must be initiated within 6 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. Diagnosis and treatment of periodontal disease when recommended by a Health Care Provider based on health related impacts or further deterioration in existing acute or chronic disease state due to gum disease, including but not limited to periodontal scaling and root planing.

F. 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.

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

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

I. Positron emission tomography (PET) Scan with a prostate cancer diagnosis. Coverage shall be provided for at least two types of PET scans upon initial prostate cancer diagnosis. Benefits for additional PET scans are available every six months per Member per Benefit Period or as Medically Appropriate and Necessary if requested by a Professional Health Care Provider.

J. Dialysis Treatment.

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

L. 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 Network Provider or BCBSND.

M. Phenylketonuria. Testing, diagnosis and treatment of Phenylketonuria, including dietary management and formulas.

N. Amino acid-based elemental oral formulas. Coverage for medical foods and low-protein modified food products determined by a Physician to be Medically Appropriate and Necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

O. Dental anesthesia and hospitalization for dental care. Precertification is required.

2.6 WELLNESS SERVICES

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

B. Preventive screening services as 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.

C. 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.

D. Diabetes care services including:

1. Diabetes care services include Outpatient Home and Office Visits, Diagnostic Services, Outpatient Nutritional Care Services, Diabetes Education Services, Dilated Eye Examinations and Diabetes Supplies.

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

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

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

2.7 OUTPATIENT THERAPY SERVICES

A. Rehabilitative Therapy

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

B. Habilitative Therapy

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

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

Benefits are subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1, for each type of Therapy under an individual medical plan (IMP) developed for each Member.

C. Other Therapy Services

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

2. Cardiac rehabilitation services.

3. Pulmonary rehabilitation services.

4. Vision Therapy: Including orthoptics and pleoptic training.

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 2 ultrasounds per pregnancy unless, based on the Member's condition and history, additional services are determined to be Medically Appropriate and Necessary.

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

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

Benefits for lactation counseling are available.

2.10 FAMILY PLANNING SERVICES

Benefits include contraceptive services, sexually transmitted disease testing, follow up care, reproductive health services and sterilizations. The Member can receive these services from a Network or Out-of-Network Provider or from any family planning provider without an Authorized Referral.

2.11 CONTRACEPTIVE SERVICES

Contraceptive services include birth control devices prescribed and dispensed by a Network or Out-of-Network Provider or family planning provider and related Office Visits. Benefits Include:

A. Injections for birth control purposes.
B. Diaphragm or cervical cap.
C. Surgical implantation and removal of a contraceptive device.
D. Insertion and removal of an Intrauterine Device (IUD).
E. Outpatient surgical sterilization and related services. See Inpatient and Outpatient Surgical Services.
F. Contraceptive Prescription Medications and Drugs, Including birth control pills, patches and vaginal rings.

Retail outpatient pharmacy benefits are administered by the North Dakota Department of Health & Human Services and not by BCBSND. Members should contact the North Dakota Department of Health & Human Services with questions about pharmacy benefits.

2.12 PSYCHIATRIC AND SUBSTANCE USE SERVICES

Guidelines and criteria for Medically Appropriate and Necessary services are available from BCBSND.

A. Psychiatric Services

1. Inpatient

   Benefits are available for the Inpatient treatment of psychiatric illness, including management of medical problems related to an eating disorder diagnosis, when provided by an appropriately licensed and credentialed Hospital or Psychiatric Care Facility. Precertification may be required for Inpatient Hospital Admissions. See Section 3, Authorizations.

2. Residential Treatment

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

3. Partial Hospitalization

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

4. Intensive Outpatient Program

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

5. Outpatient

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

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

B. Substance Use Services

1. Inpatient

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

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

2. Residential Treatment

   Benefits are available for the Residential Treatment of substance use when provided at an appropriately licensed and credentialed Residential Treatment Center. Precertification is required.

3. Partial Hospitalization

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

4. Intensive Outpatient Program

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

5. Outpatient

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

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

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

C. Behavioral Health Crisis Services.

D. Quantitative treatment limits (QTL), Including annual episode or lifetime day or visit limits, do not apply to services for psychiatric and substance use disorders regardless of whether the services also may be considered a service for a medical or surgical condition.

2.13 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.

Air Ambulance

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

2.14 SKILLED NURSING FACILITY SERVICES

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

2.15 HOME HEALTH CARE SERVICES

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

A. Covered Services include:

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

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

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

2.16 HOSPICE SERVICES

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

2.17 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.

2.18 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 Precertification 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. Precertification may be required, see Section 3, Authorizations.

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

B. Prosthetic Appliances and Limbs

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

Benefits are available for externally worn breast prostheses and surgical bras, including necessary replacements following mastectomy, subject to a Maximum Benefit Allowance of 2 external prostheses and 2 bras per Member per Benefit Period. For a double mastectomy, allow a Maximum Benefit Allowance of 4 external prostheses and 2 bras per Member per Benefit Period.

Benefits are not available for dental appliances (expect as listed in the Schedule of Benefits, Section 1), 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 available over the counter or those 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.

E. Oxygen

Administration of oxygen, Including the rental of equipment.

F. Ostomy Supplies

G. Habilitative Therapy Devices

Benefits are available for devices when provided as part of Habilitative Therapy.

H. Hearing Aids.

Benefits are available subject to the Maximum Benefit Allowance listed in the Schedule of Benefits, Section 1. Precertification is required.

2.19 BREAST PUMPS

Benefits are available for the rental or purchase of a breast pump when provided by a network Home Medical Equipment Supplier. The rental cost shall not exceed the Allowance of such equipment. No benefits are available for nursing-related supplies, Including bottles, breast milk storage bags and supplies related to bottles. Covered Services include replacement and repairs when Medically Appropriate and Necessary.

2.20 TELEHEALTH

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

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

2.21 CASE MANAGEMENT

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services required to meet an individual's comprehensive health needs, using communication and available resources to promote patient safety, quality of care and cost effective outcomes.

BCBSND provides a voluntary case management program to Members that require these services.

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

- Authorized Referrals received from Members or Providers;
- 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.

2.22 TRANSPORTATION SERVICES

Transportation for medical care may be available through BCBSND if no other source is available. Members must receive approval from BCBSND for all non-emergency transportation at least 2 business days in advance of the scheduled appointment. This includes travel to and from medical checkups. Transportation by ambulance is paid for by BCBSND when used for emergency care. Ambulance transportation is also paid in non-emergency situations when a Precertification is obtained from BCBSND. Members will not be reimbursed by BCBSND for benefit payments made by the Member directly to the provider of services. You can call BCBSND Member Services at the number listed on the back of your Identification Card or TTY:711.

2.23 MEALS AND LODGING SERVICES

Benefits for meals and lodging may be allowed only when medical services or transportation require a Member to be away overnight. Members must receive approval from BCBSND for Meals and lodging at least 2 business days in advance of the scheduled appointment. Members will not be reimbursed by BCBSND for benefit payments made by the Member directly to the provider of services. You can call BCBSND Member Services at the number listed on the back of your Identification Card or TTY:711.

2.24 **1915(i) SERVICES**

1915(i) services are benefits available under this Benefit Plan for eligible Members with behavioral health conditions. Services include but are not limited to:

1. Care coordination
2. Benefit planning services
3. Training and support for unpaid caregivers
4. Peer Support
5. Non-Medical Transportation
6. Community Transition Services
7. Supported Education
8. Pre-Vocation Training
9. Supported Employment
10. Housing Supports

Benefit payments will not be made to the Member for Covered Services.

SECTION 3
AUTHORIZATIONS

This section describes BCBSND's authorization requirements for specific Covered Services and the Member's responsibilities for these authorizations. The Member's medical care is between the Member and the Member's Health Care Provider. **The ultimate decision on the Member's medical care must be made by the Member and the Member's Health Care Provider. 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 Precertification grants to that Health Care Provider authority to act on behalf of the Member as the Member's Authorized Representative. As an Authorized Representative, the Health Care Provider assumes responsibility to act on behalf of the Member in pursuing a Claim for Benefits or appeal of an Adverse Benefit Determination from a Claim for Benefits. See Section 6, Claims for Benefits, Appeals and Grievances.

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

3.1 PRECERTIFICATION PROCESS

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

- air Ambulance (non-emergent)
- artificial intervertebral disc
- autologous chondrocyte implantation
- bariatric surgery
- bone growth stimulator (electrical or ultrasound)
- chimeric antigen receptor (CAR) t-cell therapy
- cochlear implant
- deep brain stimulator
- dental anesthesia and hospitalization
- electrical nerve stimulation (TENS, PENS, phrenic nerve stimulator, implantable peripheral nerve stimulator, occipital nerve stimulation)
- gastric electrical stimulation
- gender reassignment/affirmation surgery
- gene therapy
- hearing aids
- Home Health Care
- Hospital bed
- hyperbaric oxygen therapy
- hypoglossal nerve stimulator
- Inpatient Admission to a Rehabilitation Facility
- Inpatient Admissions with the exception of maternity and emergency Admissions
- insulin infusion pump, patient owned continuous glucose monitoring systems and artificial pancreas device systems
- intensity-modulated radiotherapy (IMRT)
- limb lengthening
- Long Term Acute Care Facility
- minimally invasive fixation/fusion of the sacroiliac joint
- oral appliance for obstructive sleep apnea

- oscillatory devices for respiratory conditions (cough stimulating device)
- osseointegrated dental implants
- percutaneous balloon kyphoplasty, radiofrequency kyphoplasty and mechanical vertebral augmentation
- positron emission tomography (PET) scan
- programmable lymphedema pumps
- Prosthetic Limbs and any Prosthetic Limb replacement
- proton beam therapy
- radiofrequency facet denervation
- Residential Treatment
- Restricted Use Drugs
- sacral nerve stimulator (trial placement and permanent placement)
- services or procedures which could be considered Cosmetic Services
- Skilled Nursing Facility
- speech generating device
- spinal cord stimulator (trial placement and permanent placement)
- surgical treatment of femoracetabular impingement (FAI)
- Transitional Care Unit
- transplants
- tumor treatment field
- unilateral or bilateral fully or partially implantable bone anchored hearing devices
- vagus nerve stimulator
- wearable cardioverter defibrillators
- wheelchairs; electric wheelchairs and accessories and manual wheelchairs with accessories

To request Precertification, 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 Precertification. The Member's Health Care Provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary.

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

Receipt of Precertification does not guarantee payment of benefits. <u>All</u> 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.

Precertification is required prior to obtaining services.

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

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

Notification Responsibility

If a Member seeks Covered Services, the Provider assumes responsibility for all Precertification requirements.

BCBSND will issue a notice of approval or denial following review of the Precertification request.

3.2 APPROVAL PROCESS FOR TRANSPORTATION, MEALS AND LODGING SERVICES

The Member is responsible to obtain approval from BCBSND for transportation, meals and lodging at least 2 business days in advance of the scheduled appointment. You can call BCBSND Member Services at the number listed on the back of your Identification Card or TTY:711.

Services requiring approval:

- transportation including non-emergent transportation
- meals
- lodging

Members will not be reimbursed by BCBSND for benefit payments made by the Member directly to the provider of services.

3.3 CONCURRENT REVIEW

Concurrent review is the ongoing review of the Medical Appropriateness and Necessity of the required Admissions outlined in Section 3.1 to an Institutional Health Care Provider.

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.

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 EXCLUSION

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. Education programs or tutoring services (not specifically defined elsewhere), Including education on self-care or home management.

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

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

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

   Special education, Including lessons in sign language to instruct a Member whose ability to speak has been lost or impaired to function without that ability, is not covered.

6. Counseling or Therapy Services, Including bereavement, codependency, marital dysfunction, family dysfunction, sex or interpersonal relationships.

7. Pharmacological detoxification management, except as specified in Section 2.12.

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

9. Any drug, device, medical service, treatment or procedure that is Experimental or Investigative.

10. Services, treatments or supplies that BCBSND determines are not Medically Appropriate and Necessary.

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

12. Services that are related to annual, periodic or routine examinations, except as specifically allowed in the Covered Services Section of this Benefit Plan.

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

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

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

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

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

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

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

17. 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 or if the pregnancy is a result of an act of rape or incest. No benefits are available for removal of all or part of a multiple gestation.

20. Services related to infertility, Including Assisted Conception, donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of sperm, embryos or unfertilized eggs, Surrogate pregnancy and delivery, Gestational Carrier pregnancy and delivery, and preimplantation genetic diagnosis testing.

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

    Assisted Conception - a pregnancy resulting from insemination of an egg of a woman with sperm of a man by means other than sexual intercourse or by removal and implantation of a fertilized egg, gamete, zygote or embryo after sexual intercourse.

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

22. Outpatient Prescription Medications or Drugs, medications obtained either with or without a Prescription Order or for any charges for the administration of legend drugs or insulin that may be Self-Administered unless such administration is Medically Appropriate and Necessary or specifically allowed under this Benefit Plan. Outpatient pharmacy benefits are administered by the North Dakota Department of Health & Human Services and not by BCBSND. Members should contact the North Dakota Department of Health & Human Services with questions about pharmacy benefits.

23. Drugs administered by a Professional Health Care Provider in an Outpatient setting that are not eligible for federal rebates per the Centers for Medicare and Medicaid Services guidelines.

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

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

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

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

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

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

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

30. Wigs, cranial prosthesis or hair transplants.

31. Orthotic Devices available over the counter, 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.

32. Palliative or cosmetic foot care, foot support devices (including custom made foot 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 custom diabetic shoes and inserts, and the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with diabetes. Benefits are available for the care of corns, calluses and toenails when Medically Appropriate and Necessary for Members with circulatory disorders of the legs or feet.

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

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

35. No benefits are available for a tinnitus masker.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

53. Services prescribed by, performed by or under the direct supervision of an Out-of-Network Provider, except as specifically allowed in the Covered Services Section of this Benefit Plan.

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

55. Services when Precertification was required but not obtained.

56. Low protein modified food products or medical food for amino acid-based disease or phenylketonuria (PKU), to the extent those benefits are available under a department of health program or other state agency.

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

58. Collection and storage of umbilical cord blood.

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

60. Services received outside the United States.

61. Autopsies.

62. Health services for which a Health Care Provider's order is required but not obtained.

63. Routine circumcisions.

64. Psychiatric services in an IMD (Institution for Mental Disease).

65. Services that were denied by responsible third-party payer because third-party requirements were not followed.

66. Drug testing for non-medical necessity (e.g., employment screening).

67. Paternity testing.

SECTION 5
GENERAL PROVISIONS

5.1 STATUS OF MEMBER ELIGIBILITY

The North Dakota Department of Health & Human Services determines eligibility and furnishes the required information to BCBSND. A Member will lose eligibility and coverage for the North Dakota Medicaid Expansion Program when any of the following occurs:

1. The Member ceases to be a resident of North Dakota or moves outside of the state of North Dakota.
2. The Member ceases to satisfy any eligibility requirement for the North Dakota Medicaid Expansion Program.
3. The Member is enrolled in or covered by Medicare, North Dakota's Traditional Medicaid program, or any other state's Medicaid program.
4. The Member dies.

Medicare Exclusion. This Certificate of Insurance does not cover Members who are eligible for or covered under any Medicare program. If it is determined that a Member was eligible for or had coverage under Medicare while covered under Medicaid Expansion, the Member's coverage under Medicaid Expansion shall cease and may be retroactively terminated to the date Medicare eligibility occurred, as determined by the North Dakota Department of Health & Human Services.

Any questions regarding eligibility must be directed to the North Dakota Department of Health & Human Services. The Department can be reached at (701) 328-2321 | (844) 854-4825 (toll-free) | TTY: 711.

This Benefit Plan does not cover newborns or dependents. Members who become pregnant will have an opportunity to change to North Dakota's Traditional Medicaid program.

The Department of Human Services will notify a Member of the effective date of coverage. BCBSND will mail the Member an Identification Card and enrollment packet with plan materials.

5.2 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 or later than 3 years after the expiration of the time within which notice of a claim is required by this Benefit Plan. Additionally, no legal action may be initiated unless the member has exhausted the Claims for Benefits, Appeals and State Fair Hearing processes in this Benefit Plan.

5.3 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 and may require an autopsy in case of death if the autopsy is not prohibited by law.

5.4 NOTIFICATION REQUIREMENTS

The Member must notify the North Dakota Department of Health & Human Services as soon as possible but no later than 10 days of the date an event may change their eligibility for coverage. Failure to timely report a change in circumstance may result in further eligibility review by the North Dakota Department of Health & Human Services, and if the review determines that a Member would have lost eligibility had the change in circumstance been timely reported, the Member will be responsible for reimbursing Health Care Providers for any Covered Services received during the identified time frame. The Member must contact their Human Service Zone office or the North Dakota Department of Health & Human Services by calling (701) 328-2321 | (844) 854-4825 (toll-free) | TTY: 711.

The following events may require a change in a Member's coverage as determined by the North Dakota Department of Health & Human Services:

1. Active duty in the military.
2. Eligibility or enrollment in Medicare.
3. Enrollment in North Dakota's Traditional Medicaid Program.
4. Death.
5. Pregnancy.
6. Change in the number of people in the Member's household.
7. Incarceration or release from incarceration.
8. Change in citizenship status or Native Alaskan/Native American Tribal affiliation.
9. Change in employment status.
10. Change in income including any increase or decrease with salary tips or shifts.
11. Change in legal residency or a move outside the state of North Dakota.

5.5 CANCELLATION OF THIS OR PREVIOUS BENEFIT PLANS

A Member's enrollment and coverage under this Benefit Plan will terminate at the date and time determined by the North Dakota Department of Health & Human Services when the Member ceases to comply with any eligibility requirements for the North Dakota Medicaid Expansion Program. BCBSND will not initiate a Member's disenrollment and termination of coverage unless such a request is at the direction of the North Dakota Department of Health & Human Services.

5.6 NOTICE TO MOTHERS AND NEWBORNS

BCBSND will not 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. The mother's or newborn's attending Health Care Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Health Care Provider is not required to obtain authorization from BCBSND for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5.7 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 Member 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 authorization 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.

5.8 BCBSND'S RIGHT TO RECOVERY OF PAYMENT

To the extent permitted by applicable laws, 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 offset 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.

5.9 CONFIDENTIALITY AND SECURITY

All Protected Health Information (PHI) maintained by BCBSND under this Benefit Plan is confidential. Unless otherwise provided by law, 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.

BCBSND has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Member's PHI that BCBSND creates, receives, maintains, or transmits.

5.10 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.

5.11 COORDINATED SERVICES PROGRAM (CSP)

Members utilizing health care services at a frequency or amount that is not Medically Appropriate and Necessary and exceeds generally accepted medical standards at the discretion of BCBSND, will be placed in a CSP after review by BCBSND and in consultation with the North Dakota Department of Health & Human Services. The following criteria will be used to determine if the CSP is appropriate:

1. Seriousness of incorrect, improper or excessive utilization of services;
2. Historical utilization of the Member; and
3. Availability of a coordinated services physician.

When a Member is placed in the CSP, BCBSND will provide written notice to the Member, which will include:

1. The reason why the Member is being placed on the CSP;
2. The Member's right to file an appeal; and
3. The timeframe in which the Member has to file an appeal.

Once a Member has exhausted BCBSND's internal appeals process, the Member has a right to a State fair hearing. BCBSND will notify the Member of the timeframe in which to file a request. The CSP administered by BCBSND is in compliance with the requirements set forth in 42 CFR §431.54.

SECTION 6
CLAIMS FOR BENEFITS, APPEALS AND GRIEVANCES

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. BCBSND will provide Members with assistance in completing forms and taking other procedural steps related to a Claim for Benefits or appeal.

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

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

Type of Claim for Benefits	Time Frame for BCBSND to respond
Standard Preservice Claim for Benefits	Written response within 14 days
Emergency Preservice Claim for Benefits	Verbal response within 72 hours, followed by written response within 3 days
Post Service Claim for Benefits	Written response within 30 days

6.1 CLAIM FOR BENEFITS INVOLVING PRECERTIFICATION (PRESERVICE CLAIM FOR BENEFITS)

A PreService Claim for Benefits is defined as a request, either verbal or written, that is conditioned on a Member and/or a Member's Authorized Representative obtaining approval in advance of obtaining the benefit or service. There are two levels of PreService Claim for Benefits:

1. **Standard** - BCBSND will provide a written determination for a Standard PreService Claim for Benefits as expeditiously as the Member's health condition requires but no later than 14 days after receipt of the Claim for Benefits. BCBSND may extend this time period an additional 14 days if the Member and/or a Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the interest of the Member.

2. **Emergency** - An Emergency PreService Claim for Benefits occurs when the above timeframe for the Standard PreService Claim for Benefits would seriously jeopardize the Member's life, health or ability to attain, maintain or regain maximum function. BCBSND notifies the Member and/or the Member's Authorized Representative as soon as possible but no later than 72 hours after receipt of the Claim for Benefits. BCBSND may extend this time period an additional 14 days if the Member and/or a Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the interest of the Member.

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

A Post Service Claim for Benefits is a request, either verbal or written, from the Member and/or a Member's Authorized Representative expressing disagreement with a claim that has been processed correctly according to the Member's Benefit Plan. The Member has 18 months from the claim processed date to make a Claim for Benefits. BCBSND will respond to the Claim for Benefits within 30 days upon receipt of all relevant information. Any Claim for Benefits received after the 18 months will be returned to the Member without review.

6.3 APPEALS OF CLAIM FOR BENEFITS

A. The Member and/or the Member's Authorized Representative may appeal Adverse Benefit Determinations.

Type of Appeal	Time Frame for BCBSND to respond
Standard PreService Claim for Benefits	Written response within 30 days
Emergency PreService Claim for Benefits	Verbal response within 72 hours, followed by written response within 3 days
Post Service Claim for Benefits	Written response within 60 days

1. **Appeals of Standard PreService Claims for Benefits.** The Member and/or the Member's Authorized Representative have 60 days from the date on the Adverse Benefit Determination notice in which to appeal BCBSND's Adverse Benefit Determination of a Standard PreService Claim for Benefits either verbally or in writing. A verbal appeal must be followed by a written, signed appeal. BCBSND will provide a written determination for the appeal as expeditiously as the Member's health condition requires but no later than 30 days after receipt of the appeal. BCBSND may extend this time period an additional 14 days if the Member and/or the Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the interest of the Member.

2. **Appeals of Emergency PreService Claims for Benefits.** The Member and/or the Member's Authorized Representative have 60 days from the date on the Adverse Benefit Determination notice in which to appeal BCBSND's benefit determination of an Emergency PreService Claim for Benefits either verbally or in writing. BCBSND will provide a written determination for the appeal as expeditiously as the Member's health condition requires but no later than 72 hours after receipt of the appeal. BCBSND may extend this time period an additional 14 days if the Member and/or the Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and the delay is in the interest of the Member.

3. **Appeals of Post Service Claims for Benefits.** The Member and/or the Member's Authorized Representative have 60 days from the date on the Adverse Benefit Determination notice in which to appeal BCBSND's Adverse Benefit Determination of a Post Service Claim for Benefits either verbally or in writing. A verbal appeal must be followed by a written, signed appeal. BCBSND will provide a written determination for the appeal as expeditiously as the Member's health condition requires but no later than 30 days after receipt of the appeal. BCBSND may extend this time period an additional 14 days if the Member and/or the Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the interest of the Member.

B. **Appeal Rights and Standard Appeal Procedure**

A Member and/or the Member's Authorized Representative may initiate an appeal of an Adverse Benefit Determination either verbally or in writing. The date of a verbal appeal request will be used as the appeal date and must be confirmed by the Member and/or the Member's Representative in writing. BCBSND will acknowledge receipt of the Member's and/or the Member's Authorized Representative's appeal.

The Member and/or the Member's Authorized Representative may present, in person and in writing, comments, documents, record, other evidence and testimony and make legal and factual arguments as part of the appeal. BCBSND will provide the Member and/or the Member's Authorized Representative with notice of the limited time available for these presentations sufficiently in advance of the appeal resolution timeframes.

BCBSND will provide the Member and/or the Member's Authorized Representative sufficiently in advance of the 30 days of BCBSND's receipt of appeal resolution and free of charge with the Member's case file, including medical records, other documents and records and any new or additional evidence considered relied upon or generated by or at the direction of BCBSND in connection with the appeal.

BCBSND will ensure that an individual or, if appropriate, a Medical Director/Medical Consultant who was neither involved in the Claim for Benefits review or decision making nor a subordinate of any such persons will review the appeal. The Medical Director/Medical Consultant will be board certified in the same or similar specialty as a Health Care Provider who typically manages the medical condition appealed. The review will take into consideration all comments documents, records and other information submitted by the Member and/or the Member's Authorized Representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

If BCBSND extends the timeframe for an appeal determination up to 14 days by demonstrating there is a need for additional information and that the delay is in the best interest of the Member, BCBSND will make reasonable efforts to give the Member and/or the Member's Authorized Representative prompt verbal notice of the delay. BCBSND will provide the Member and/or the Member's Authorized Representative with written notice of the decision to extend the timeframe within 2 days and the Member and/or the Member's Authorized Representative may file a Grievance if they disagree with the timeframe extension. BCBSND will resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the timeframe extension expires.

The parties to an appeal include BCBSND, the Member and/or the Member's Authorized Representative and in the case of a deceased Member, a representative of the Member's estate.

BCBSND will provide the Member and/or the Member's Authorized Representative with timely written notice of the appeal determination in a form and manner consistent with federal law.

If BCBSND fails to adhere to the notice and timing requirements related to appeals, the Member is deemed to have exhausted BCBSND's appeals process and may initiate a State Fair Hearing.

If BCBSND reverses the Adverse Benefit Determination for services that were not furnished while the appeal was pending, BCBSND must authorize the disputed services promptly and as expeditiously as the Member's health condition requires but no later than 72 hours from the date BCBSND reverses the Adverse Benefits Determination.

If BCBSND reverses its Adverse Benefit Determination denying authorization of services and the Member received the disputed services while the appeal was pending, BCBSND will pay for those services.

If the final resolution of the appeal is adverse to the Member by upholding BCBSND's Adverse Benefit Determination, the Member may be responsible for the cost of services received while the appeal was pending.

C. **Expedited Appeal Procedures**

The procedures in this section apply when BCBSND determines, or the Member's Health Care Provider indicates, that the timeframe for a standard appeal determination could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. These expedited appeal procedures are in addition to the standard appeal procedures described above.

The Member and/or a Member's Authorized Representative may submit a request for an expedited appeal either verbally or in writing. If the request is verbal, a follow-up written, signed appeal is not required. In addition to providing written notice, BCBSND will make reasonable efforts to provide verbal notice of the expedited appeal resolution no later than 72 hours after receipt of the expedited appeal.

BCBSND will not take punitive action against a Health Care Provider who requests an expedited appeal resolution or supports a Member's expedited appeal.

If BCBSND extends the timeframe for an appeal determination up to 14 days by demonstrating there is a need for additional information and that the delay is in the best interest of the Member, BCBSND will make reasonable efforts to give the Member and/or the Member's Authorized Representative prompt verbal notice of the delay. BCBSND will provide the Member and/or the Member's Authorized Representative with written notice of the decision to extend the timeframe within 2 days and the Member and/or the Member's Authorized Representative may file a Grievance if they disagree with the timeframe extension. BCBSND will resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the timeframe extension expires.

If BCBSND denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeal timeframe for resolution. The Member and/or the Member's Authorized Representative will receive prompt verbal notice that the appeal is not considered expedited. Verbal notice will be followed by written notice within 2 calendar days.

D. **State Fair Hearing**

The Member and/or the Member's Authorized Representative have 120 days from the date on the Adverse Benefit Determination notice of an appeal in which to request a State Fair Hearing. A State Fair Hearing request may also be initiated if BCBSND fails to adhere to the notice and timing requirements related to appeals. A State Fair Hearing is not available for a noncovered service determination.

A State Fair Hearing must be filed with the North Dakota Department of Health & Human Services at:

Appeals Supervisor, Legal Advisory Unit
North Dakota Department of Health & Human Services
600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-2311 Toll-Free: (800) 472-2622
ND Relay TTY: (800) 366-6888 (toll-free)
Email: dhslau@nd.gov

The parties to the State Fair Hearing include BCBSND, the Member and/or the Member's Authorized Representative and in the case of a deceased Member, a representative of the Member's estate.

If the State Fair Hearing officer reverses BCBSND's Adverse Benefit Determination for services that were not furnished while the State Fair Hearing was pending, BCBSND must authorize the disputed services promptly and as expeditiously as the Member's health condition requires but no later than 72 hours from the date BCBSND received the State Fair Hearing Officer's notice reversing the Adverse Benefit Determination.

If the State Fair Hearing officer reverses BCBSND's Adverse Benefit Determination denying authorization for services and the Member received the disputed services while the State Fair Hearing was pending, BCBSND will pay for those services.

If the final resolution of the State Fair Hearing is unfavorable to the Member by upholding BCBSND's appeal Adverse Benefit Determination, the Member may be responsible for the cost of services received while the appeal was pending.

E. **Continuation or Reinstatement of Benefits**

BCBSND will continue the Member's benefits previously authorized while the appeal and/or the State Fair Hearing are pending if:

1. The Member files for continuation of benefits within 10 days of BCBSND's sending of the Adverse Benefit Determination notice or the intended effective date of BCBSND's proposed Adverse Benefits Determination, whichever timeframe is later;

2. The appeal involves the termination, suspension or reduction of previously authorized services;
3. The services were ordered by an authorized Health Care Provider; and
4. The period covered by the original authorization has not expired.

If BCBSND continues or reinstates the benefits while the appeal or State Fair Hearing is pending, the benefits will continue until one of the following occurs:

1. The Member withdraws the appeal or request for a State Fair hearing;
2. The Member fails to request a State Fair Hearing and continuation of benefits within 10 days after BCSND sends the Adverse Benefit Determination notice for the appeal;
3. The State Fair Hearing office issues a hearing decision adverse to the Member; or
4. The period of the original authorization has expired.

BCBSND may recover the cost of the continuation or reinstatement of benefits provided to the Member while the appeal or State Fair Hearing was pending if the final resolution of the appeal or State Fair Hearing is unfavorable to the Member.

6.4 GRIEVANCES

The Member and/or the Member's Authorized Representative may express dissatisfaction regarding any matter other than an Adverse Benefit Determination by filing a verbal or written Grievance with BCBSND at any time. BCBSND will acknowledge receipt of the Member's and/or Member's Authorized Representative's Grievance within 5 business days of receipt of the Grievance.

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

BCBSND will provide a written determination of a Grievance as expeditiously as the Member's health condition requires but no later than 90 days after BCBSND's receipt of the Grievance.

BCBSND may extend this time period an additional 14 days if the Member and/or the Member's Authorized Representative requests the extension or if BCBSND demonstrates there is a need for additional information and that the delay is in the interest of the Member. If BCBSND extends the timeframe for an appeal determination up to 14 days by demonstrating there is a need for additional information and that the delay is in the interest of the Member, BCBSND will give the Member and/or the Member's Authorized Representative verbal notice of the delay by the end of the business day in which the extension determination is made. BCBSND will provide the Member and/or the Member's Authorized Representative with written notice of the decision to extend the timeframe within 2 days, and the Member and/or the Member's Authorized Representative may file a Grievance if they disagree with the timeframe extension. BCBSND will resolve the Grievance as expeditiously as the Member's health condition requires and no later than the date the timeframe extension expires.

BCBSND will ensure the individuals making decisions on Grievances were neither involved in any previous level of review or decision making nor a subordinate of any such individual. If a Grievance requires review by a BCBSND Medical Director/Medical Consultant, the reviewer will be board certified in the same or similar specialty as a Health Care Provider who typically manages the medical condition appealed. The review will take into consideration all comments documents, records and other information submitted by the Member and/or the Member's Authorized Representative without regard to whether such information was previously submitted or considered.

The Member and/or the Member's Authorized Representative, upon request and free of charge, can receive copies of documents used by BCBSND to resolve the Grievance.

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

SECTION 7
OTHER PARTY LIABILITY

BCBSND shall determine the interpretation and application of the provisions of this Benefit Plan in each and every situation.

7.1 COORDINATION OF BENEFITS

This section applies when a third party is responsible to pay for Covered Services received by a Member. This includes other health insurance, including group health coverage, individual health coverage, regardless of who pays premiums, Medicare, auto liability, no-fault or med pay coverage for the services, persons who agreed or were court-ordered to pay for injuries caused by products, medical malpractice, workers compensation programs, etc. This plan is the payer of last resort except when federal law provides otherwise. If the sum of benefits payable under this Benefit Plan and by the third party exceeds 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.

The Member shall inform BCBSND of third parties who may be responsible to pay for Covered Services as soon as possible but no later than 30 days after receiving the services. Failure to do so my result in the provider's claim being rejected to bill the appropriate third party. The Member assigns all rights, interest and claim to any benefits payable to or on behalf of the Member by any third party responsible to pay for health care services paid by BCBSND under this Benefit Plan.

In the event a Member fails to comply with this provision, BCBSND shall have full discretion to withhold payment of any future benefits to or for the Member and to offset benefits already paid to or for the Member against the payment of any future benefits to or for the Member.

7.2 RIGHTS OF SUBROGATION, REIMBURSEMENT AND ASSIGNMENT

If BCBSND pays benefits for Covered Services a third party is responsible for, BCBSND may pursue reimbursement of such overpayment from such third party. BCBSND may elect not to pursue recoveries where the anticipated recovery is lower than the likely administrative expense of pursuing reimbursement.

A Member must promptly notify BCBSND of the circumstances of any injury or condition suffered in the course of employment or caused or contributed to by any third party at fault. The Member assigns all rights, interest and claim to compensation from an employer, responsible third party insurance coverage or their source, for such condition or injury for which no claim has been timely made by or on behalf of the Member. As the assignee and/or subrogee of the Member BCBSND has the right to bring any claim not made by the Member and to recover any benefits paid under this Benefit Plan from the employer, responsible third party, insurance coverage of either, or any other source of compensation available to compensate the Member for such injury or condition. The Member must cooperate with BCBSND, the United Sates, any interested state and any political subdivision of either one, in doing whatever is necessary to determine the availability of benefits or compensation for such condition or injury and do nothing to prejudice the rights to such benefits or compensation of the Member, BCBSND, the United States, any interested state or any political subdivision of either. 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 offset the benefits already paid to or for the Member against the payment of any future benefits to or for the Member regardless of whether or not said future benefits are related to the injury or condition.

The 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.

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.

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.

ADVERSE BENEFIT DETERMINATION - means any of the following:

1. The denial or limited authorization of a requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of a payment for a service;
4. The failure to provide services in a timely manner, as defined by the North Dakota Department of Health & Human Services;
5. The failure of BCBSND to timely to review and respond to the Grievances and appeals in accordance with the timeframes in this Benefit Plan and federal law;
6. The denial of a Member's request to exercise their right to obtain services from an Out-of-Network Provider; and
7. The denial of a member's request to dispute any financial liability.

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

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

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

AUTHORIZED REFERRAL - a referral that is submitted by a Network Provider in accordance with the referral guidelines established by BCBSND. To receive Covered Services from an Out-of-Network Provider, an Authorized Referral must be obtained.

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

BCBSND - Blue Cross Blue Shield of North Dakota.

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

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

BENEFIT PLAN - the agreement with BCBSND, Including the Member’s application, Identification Card, this Benefit Plan and any supplements, endorsements, attachments, addenda or amendments.

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, Appeals and Grievances. A Claim for Benefits includes Claims for Benefits Involving Precertification (Preservice Claim for Benefits) and all other Claims for Benefits (Post Service Claim for Benefits). A Claim for Benefits involving payment of a claim shall be made promptly and in accordance with state law.

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

CUSTODIAL CARE - care that 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.

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.

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.

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

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.

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 and the amount of the charges that are the Member's responsibility. This form should be carefully reviewed and kept with other important records.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) - means an entity as defined in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. §1396d(l)(2)(B)).

GRIEVANCE - an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

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

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

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

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

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. provides treatment by or under the direct supervision of a Professional Health Care Provider;
3. does not provide Inpatient accommodations; and
4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Health Care Provider.

D. **Audiologist**.

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

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

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

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

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

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

K. **Home Infusion Therapy Provider**.

L. **Home Medical Equipment Supplier**.

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

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

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

P. **Licensed Addiction Counselor**.

Q. **Licensed Assisted Behavior Analyst**.

R. **Licensed Behavior Analyst**.

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

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

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

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

W. **Licensed Professional Clinical Counselor**.

X. **Licensed Professional Counselor**.

Y. **Licensed Registered Dietitian**.

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

AA. **Mobile Radiology Supplier**.

BB. **Occupational Therapist**.

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

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

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

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

GG. **Pharmacist**.

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

II. **Physical Therapist**.

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

KK. **Physician Assistant**.

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

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

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

OO. **Respiratory Therapist**.

PP. **Rural Health Care Provider (RHC)**.

QQ. **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.

RR. **Sleep Lab**.

SS. **Speech Therapist**.

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

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

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

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

IDENTIFICATION CARD - a card issued in the Member’s name identifying the Unique Member Identifier of the Member.

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

INCLUDING - means including, but not limited to.

INDIAN HEALTH CARE PROVIDER (IHCP) - a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or Urban Indian Organization (otherwise known as I/T/U) as those terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

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

INSTITUTION FOR MENTAL DISEASES (IMD) - a Hospital, nursing facility or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of Members with mental diseases, including medical attention, nursing care and related services.

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 Use Facility or Transitional Care Unit.

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

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

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

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

MEDICALLY APPROPRIATE AND NECESSARY - services, supplies or treatments provided by a Health Care Provider to treat an illness or injury that satisfy all the following criteria as determined by 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.

MEMBER - any individual who is enrolled in the Plan.

NETWORK PROVIDER - Health Care Providers contracted with BCBSND for the ND Medicaid Expansion Network, enrolled with the state of North Dakota Medicaid Program and located within the Service Area. Network Providers include Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Indian Health Care Providers (IHCP).

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES - the North Dakota Department of Health & Human Services, Medicaid Services Division.

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

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

OUT-OF-NETWORK PROVIDER - Health Care Providers who do not meet all of the criteria in the Network Provider definition. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a nonpayable Health Care Provider.

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 Use Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

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

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

PRESCRIPTION MEDICATION OR DRUG - any legend drug or 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. **Restricted Use Drug** - a Prescription Medication or Drug that may require Precertification and/or be subject to a limited dispensing amount.

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.

PRIMARY CARE PROVIDER (PCP) - a group of Network Providers composed of Physicians, nurse practitioners, or Physician assistants who accept primary responsibility for the management of a Member's health care.

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

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

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

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

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

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

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

SERVICE AREA - the geographic area including all counties within North Dakota plus one contiguous county into the bordering states of Minnesota, South Dakota, and Montana wherein BCBSND maintains a Network of Providers.

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

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

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

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

The following definitions apply to Telehealth:

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

E-Visit - a face-to-face digital communication initiated by a patient to a Health Care Provider through the Health Care Provider's online patient portal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TTY/TDD - Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

UNIQUE MEMBER IDENTIFIER - a number assigned by BCBSND and listed on the Identification Card that identifies the Member for administrative purposes.

URGENT CARE - medical care provided for a condition that, without timely treatment, could be expected to deteriorate into an emergency, or case prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require Urgent Care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of the Members notification of the existence of an urgent condition.