ANNUAL MEMBER NOTICE

To make the most of your Blue Cross Alternative Health Plan designed by Coupe Health, it's important to understand your health coverage and take an active role in your health care. This notice provides important information to help you understand and where to locate important information about your health plan coverage.

For more information on the topics below or other questions related to your health insurance, please contact your Health Valet at the number on the back of your member identification (ID) card. If you need language translation services, your Health Valet can help no matter what language you speak. If you are hearing or speech impaired, please use Minnesota Relay Services by calling 711.

Benefits of Blue Cross

Blue Cross knows that you have options when it comes to health care, and that's why we continue to work to be the best and provide you with outstanding services, including:

- The **Largest Provider Network** so you can get the care you need when you need it.
- **Experienced Health Plan Team** health coaches and Health Valet representatives dedicated to providing you with the information and help you need.
- **Online Tools and Resources** easy access to information about your care.

Your Rights and Responsibilities

As a member, you have rights and responsibilities when receiving health care. Understanding them can help you make the most of your membership. As your health care partner, we want to make sure your rights are respected. That means giving you access to our network of health care providers and the information you need to make the best decisions for your health. Your rights and responsibilities as a health plan member are noted below.

Member Rights

As a member of the plan, you have the right to:

1. Receive information about Blue Cross, its services, its practitioners and providers and member rights and responsibilities.
2. Be treated with respect and recognition of your dignity and your right to privacy.
3. Participate with providers in making decisions about your healthcare.
4. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. Voice complaints or appeals about us, or the healthcare the plan provides.
6. Make recommendations regarding our member rights and responsibilities policy.

Member Responsibilities

As a member of the plan, you have the responsibility to:

1. Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
2. Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
3. Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

A paper copy of this notice may be requested by contacting your Health Valet at the number on the back of your member identification (ID) card.

Understanding Your Coverage

The Health Care Certificate or Contract is a document that describes your health care benefits in detail. This document may also be referred to as a benefit book. It provides documentation of what that plan covers and how it works, including how much you pay. It's a good idea to review this document each year. Your health plan or employer should provide you with a copy annually. A copy can be requested through your Benefits Administrator or by calling your Health Valet. Your plan may have access to additional benefits, in certain situations. Those benefits include:

- Getting a second opinion.
- Choosing any in-network doctor, clinic, hospital, pharmacy, or family planning agency for services such as family planning, testing for infertility, testing and treatment of sexually transmitted diseases, testing for AIDS and HIV, or women's routine and preventive health services.
- Receiving coverage for out-of-network services if the service is a covered benefit and there is not an in-network provider who can perform the service.
- To learn more about these benefits and others that may be available to you, contact Your Health Valet.
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You can also learn more about your benefits and access to medical services by visiting **www.coupehealth.com** and logging in or calling your Health Valet at the number on the back of your ID card.

Preventive Care Services

Preventive care can help you stay healthy throughout your life. Preventive care services include routine physicals and annual wellness visits, plus screenings and immunizations that are used to prevent illnesses, disease and other health problems. Preventive care can identify health concerns or conditions in the early stages of development when treatment is likely to work best.

For information on preventive services and immunizations covered by your plan, call your Health Valet at the number located on the back of your member ID card.

NOTICE: The information contained here is a summary of coverage and not a contract. If statements in this document differ from the contracts, the terms and conditions of those contracts will prevail. For more detailed information about benefit provisions, contact the Health Valet Department at the telephone number on the back of your insurance card.

Prior Authorizations

Our Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of medical coverage through your plan policy. We do not compensate providers, practitioners or other individuals conducting decision-making activities for denials of coverage or service. We do not offer incentives to decision-makers to encourage denials of coverage or service that would result in less than appropriate care or under-utilization of appropriate care and services.

UM decision-making processes ensure that members are not discriminated against based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genetic information. Individual needs, health plan benefits and clinical criteria are considered when making a decision. Core processes used to guide staff performing UM functions are:

- Confidentiality: Personal health information is kept confidential in accordance with state and federal laws, including limiting access to only the information necessary to complete the review.
- Open Process: Physicians, licensed clinicians, members, and patient representatives are given the opportunity to provide essential information to clinical staff.

How to Appeal

The appeal information provided is an overview of the appeal process for most of our benefit plans. Appeal rights specific to your plan are explained in detail in your benefit booklet. We encourage you to consult your benefit booklet for specific appeal information.

You may file an appeal with us for any adverse benefit determination concerning claims payment or your precertification denials. You have 180 days to file your appeal after receiving the notice that the service is not approved for coverage. You may file the appeal by telephone or in writing. If your need for care is urgent, we will provide our response to you as soon as possible, but no later than 72 hours after you file your appeal. This is an expedited appeal. To initiate an expedited appeal, please contact our Health Valet Department. In all other cases, we will respond within 30 days for non-urgent pre-service requests and within 60 days for post-service requests, after you file your appeal.

The following information should be included in the appeal request:

- Patient name.
- Contract number.
- Enough information to identify the claim(s) you are appealing.
- A written statement that you are filing an appeal.
- A written explanation of why you believe this service should be approved for coverage.

Please submit medical records, peer review articles, and any comments for consideration that may support your appeal. The appeal request and additional documents or information should be submitted to the appeals address located in your benefits booklet.

You may give someone else permission to appeal on your behalf. We have developed a form you must use if you wish to designate an authorized representative. To request the form, call your Health Valet at the number on the back of your member ID card. You can also request the form by email, using the Contact Us link at the top of **www.coupehealth.com.**

You may request copies of information relevant to your claim. Any request for information must be in writing.

Some members may be eligible for an external review of an appeal denial. If you are eligible for this appeal option, you will receive information about how to request an external review in your appeal decision notice. You, or your authorized representative, may file a request for an external review within four months after the date of receipt of the final adverse appeal decision.

For questions about your rights, or for assistance, you may contact our Health Valet team. You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Independent Reviews

If you disagree with a decision we've made about your appeal, you may ask for additional information or explanation by calling your Health Valet. If your appeal is about a health care service or claim or contract rescission, review by an independent organization may be available to you. In most cases, you must first exhaust the internal appeal process. Not all plans or appeals qualify for independent review. To learn about your independent review options, contact Your Health Valet or review a copy of your benefit book.

Care Management Programs

We are dedicated to providing programs and services to improve our members' health and the quality of care they receive. The Complex Case Management Program and Chronic Condition Management Program offers clinicians who help members with serious medical conditions, extensive injuries, chronic conditions, or long-term illnesses. These services are voluntary and there is no additional cost for you or your covered dependents. Our approach puts your health first.

- A clinician is available by telephone to help you and your loved one navigate the healthcare system through researching, assessing, and coordinating healthcare needs, and identifying community resources.
- Clinicians with specialty experience are available when necessary to assist with your individual needs, such as chronic and complex medical conditions, pediatrics, high-risk obstetrics (OB), organ transplants oncology services and behavioral health.
- Educational materials are provided to help you learn more about managing your condition.

Members are identified through several methods, such as claims information or through referrals. Referrals into a program may come from your doctor, a member of your care team, caregiver, or through health plan tools (e.g., utilization management). If you have been identified as eligible for a program, you may receive a call from a clinician.

If you would like to learn more about these programs, contact your Health Valet at the number on the back of your ID card. If you have been identified for one of these programs and want to learn more about the program, how to use the services, how you were identified or to request to be removed, you may contact the clinician at the number on the letter you received or contact your Health Valet for assistance.

Medical Drugs/Therapeutics

Medical drugs are medicines that you receive in a healthcare setting such as a clinic or hospital. Examples of medical drugs are infusions or injectables. They are administered to you by a healthcare provider. Medical drugs are covered under your medical benefit. They do not include drugs that process under the pharmacy benefit such as oral pills or other self-administered drugs.

For some plans, Blue Cross uses a preferred medical drug list. Your drug list will include drugs that are covered by your plan. You can also find an explanation of special requirements, such as prior authorization, step therapy or quantity limits. Please discuss any special requirements for your drugs with your prescribing physician. You can access the medical drug list by visiting www.coupehealth.com and logging in or calling your Health Valet at the number on the back of your ID card.

Medicines are selected for the prescription drug lists based on the recommendations of committees made up of physicians and pharmacists from across the country. These committees, which includes representation from Blue Cross, review drugs regulated by the U.S. Food and Drug Administration (FDA). The prescription drug lists are updated regularly and negatively impacted members are notified.

Blue Cross requires prior authorization for some covered medical drugs. Your provider may request a prior authorization review for drugs that they consider medically necessary. We provide your provider with instructions on how to request a prior authorization. Your provider will provide us with supporting documentation such as laboratory results, progress notes and other information to support the request. To determine if your drug requires a prior authorization and to learn more about our medical prior authorization process, please talk to your provider and have them visit mn-policies.exploremyplan.com.

If a prescription medication is not listed on your medical drug list (also referred to as a formulary), your provider may request an exception to the formulary or a coverage exception for any drug that they consider medically necessary. We provide your doctor with instructions on how to request a medication coverage exception. Your doctor will provide us with supporting documentation such as laboratory results, progress notes and other information to support the request. Your doctor may also submit a request to have a medication added to the formulary.

Behavioral Health Services

This section applies to you only if Lucet administers your behavioral health benefits.

Behavioral health benefits include mental health services, substance use treatment and more.

Lucet can:

- Help you find the right doctors and treatment facilities for your unique needs.
- Confirm provider participation in your health plan network.
- Give you information about people and groups in your community who can help you.
- Assist you, your doctors, and your health plan to work together toward your goals.
- Inform you about topics such as depression, anxiety, autism spectrum disorder and bipolar disorder.
- Provide information about substance use disorder, including opioid addiction.
- Offer coaching and support services through its Care Management program.

For more information or to initiate behavioral health services, you may contact your Health Valet using the number on the back of your member ID card. Licensed clinicians are available, as needed. You may also visit the Lucet website at lucethealth.com for articles, videos, guidebooks and more.

Lucet is an independent company that provides behavioral health benefit management services.

Questions?

If you have questions about any of the information in this notice, your health benefits, claims, services that require prior authorization or referral, or to obtain status of a prior authorization, contact our Health Valet at the number on the back of your member identification card. Except for the dates listed below, representatives answering the member Health Valets numbers are available to assist you Monday through Friday during business hours.

- Monday, January 1
- Monday, January 15
- Monday, May 27
- Wednesday, June 19
- Thursday, July 4
- Monday, September 2
- Thursday, November 28
- Friday, November 29
- Tuesday, December 24
- Wednesday, December 25

Thank You

We appreciate your membership and feedback. We are committed to being Minnesota's health care leader and giving you the quality treatment, you deserve. To serve you better, we occasionally conduct surveys by mail or phone. Your input is critical to helping us deliver the best quality care.