The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-363-8457 or visit www.bcbsnd.com/plandocuments. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-844-363-8457 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers **$1,000** individual / **$1,500** parent and child / **$1,500** parent and children / **$2,000** two person / **$2,000** family For out-of-network providers **$2,000** individual / **$3,000** parent and child / **$3,000** parent and children / **$4,000** two person / **$4,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, **$500** for medical infertility services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers **$3,500** individual / **$5,250** parent and child / **$5,250** parent and children / **$7,000** two person / **$7,000** family For out-of-network providers **$7,000** individual / **$10,500** parent and child / **$10,500** parent and children / **$14,000** two person / **$14,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, infertility services, nonformulary drug sanctions, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit**.**

Will you pay less if you use a network provider?	Yes. See www.bcbsnd.com/find-a-doctor or call 1-844-363-8457 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnd.com/members/rx-tools	Value drugs	$5 copay/prescription; deductible does not apply (retail & mail order)	$5 copay/prescription; deductible does not apply (retail & mail order)	Benefits are subject to the copay application described in the benefit plan. *See section 1.
	Formulary drugs	$15 copay/prescription and 20% coinsurance; deductible does not apply (retail & mail order)	$15 copay/prescription and 20% coinsurance; deductible does not apply (retail & mail order)	Benefits are subject to the copay application described in the benefit plan. *See section 1.
	Nonformulary drugs	$15 copay/prescription and 50% sanction; deductible does not apply (retail & mail order)	$15 copay/prescription and 50% sanction; deductible does not apply (retail & mail order)	Benefits are subject to the copay application described in the benefit plan. *See section 1.
	Specialty drugs	$15 copay/prescription and 20% coinsurance; deductible does not apply (formulary) $15 copay/prescription and 50% sanction; deductible does not apply (nonformulary)	$15 copay/prescription and 20% coinsurance; deductible does not apply (formulary) $15 copay/prescription and 50% sanction; deductible does not apply (nonformulary)	Benefits are subject to the copay application described in the benefit plan. *See section 1. Specialty drugs must be received from the preferred specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsnd.com/plandocuments.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance; network deductible applies	None
	Emergency medical transportation	10% coinsurance	10% coinsurance; network deductible applies	None
	Urgent care	$30 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health or substance abuse services	Outpatient services	$30 copay/office visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance/office visit 30% coinsurance for other outpatient services	No charge for first five hours of psychiatric services or first five visits for substance use services. Precertification may be required.
	Inpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Precertification is required.
	Rehabilitation services	$30 copay/visit; deductible does not apply	30% coinsurance	None
	Habilitation services	$30 copay/visit; deductible does not apply	30% coinsurance	90 visits max/benefit period may apply for each therapy: physical, occupational and speech.
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification may be required.
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	N/A
	Children's glasses	Not covered	Not covered	N/A
	Children's dental check-up	Not covered	Not covered	N/A

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (pediatric or adult)
- Long-term (custodial) care
- Routine eye care (pediatric or adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (lifetime maximum of 1 operative procedure may apply)
- Chiropractic care
- Hearing aids (1 hearing aid per ear every 3 years for members under age 18)
- Infertility treatment ($20,000 lifetime maximum)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: BCBSND at 1-844-363-8457 or www.bcbsnd.com; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: BCBSND at 1-844-363-8457 or www.bcbsnd.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or North Dakota Insurance Department at 1-701-328-2440, 1-800-247-0560 or www.nd.gov/ndins/contact.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
See BCBSND's attached disclosure for information on available language assistance services.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$60
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,280**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

In accordance with federal 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 on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

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 1-844-363-8457 (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, color, national origin, age, disability, gender identity, sexual orientation or sex, 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 within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. 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 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (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 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (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 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

(Arabic العربية**)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-363-8457 (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。1-844-363-8457（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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-363-8457 (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 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457 (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 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (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 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)

Blue Cross Blue Shield of North Dakota

Preventive Services

Good health is more than the absence of disease. It's a lifestyle of wellness and prevention. That's why preventive services are part of the 10 essential benefits included in plans that meet the criteria of the Affordable Care Act (ACA)*.

Preventive care services are for patients without recognized signs or symptoms of the target condition. Screening is the testing for disease in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease. If a screening service results in a diagnosis of a condition, the patient will be followed by a surveillance regimen and recommendations for screening are no longer applicable. The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening.

Members may have additional services and/or tests performed during a medical appointment for preventive services that are not covered under wellness services or meet ACA recommendations. Additional diagnostic services and tests may be subject to cost sharing such as deductible and coinsurance. Members should contact Member Services at the telephone number and address on the back of their Identification Card for further preventive services information.

*These specific types of preventive services, as defined under the ACA, may be covered under a Member's Benefit Plan depending on factors such as grandfathered status, product type and anniversary date, and contraception exemptions.

The terms and conditions of the written Benefit Plan govern the benefits available to members, and the guidelines do not guarantee coverage or payment for a particular service.

Preventive Service	Description
Immunizations	Immunizations recommended by the Centers for Disease Control and Prevention for age, sex, gender www.cdc.gov/vaccines.
Infants and Children	
Pediatric Preventive Visits ▪ 11 visits from birth through 35 months ▪ Annual visit after 36 months	Includes an age and gender appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.
Adult/Adolescent Preventive Services	
Annual Visit 1 visit per calendar year for ages 7 and up	Includes an age and gender appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures.
Colorectal Cancer Screening Colonoscopy ▪ 45-75 years of age ▪ 1 every 10 years Sigmoidoscopy, Proctosigmoidoscopy and CT Colonography ▪ 45-75 years of age ▪ 1 every 5 years Colon Pathology ▪ 45-75 years of age Fecal Occult ▪ 45-75 years of age ▪ 1 Per Calendar year FIT-DNA ▪ 45-75 years of age ▪ 1 every 3 years	Screening for colorectal cancer using fecal occult blood testing or FIT on an annual basis, FIT-DNA every 3 years or proctosigmoidoscopy / sigmoidoscopy / CT colonography every 5 years or colonoscopy every 10 years recommended in adults beginning at age 45 and continuing until age 75. Includes related pathology & prescription bowel prep meds. Colon pathology will process as preventive when related to a preventive colonoscopy, sigmoidoscopy or proctosigmoidoscopy. Screening for colorectal cancer using fecal occult blood testing or FIT on an annual basis, FIT-DNA every 3 years or proctosigmoidoscopy / sigmoidoscopy every 5 years or colonoscopy every 10 years recommended in adults beginning at age 45 and continuing until age 75.

Preventive Service	Description
Adult/Adolescent Preventive Services (Continued)	
Depression Screening Greater than 6 years of age	Screening of adolescents and adults when adequate systems are in place to ensure accurate diagnosis, effective treatment and follow-up.
Lipid Disorders (Cholesterol Screening) ▪ Ages 2-21 ▪ Ages 40-75	High levels of total cholesterol and low density lipoprotein-cholesterol (LDL-C) and low levels of high density lipoprotein-cholesterol (HDL-C) are risk factors for coronary heart disease. Lipid measurement can identify asymptomatic men and women who are eligible for preventive therapy.
High Blood Pressure Screening ▪ Ages 6-17 ▪ Ages 18 and older	Hypertension is a condition that contributes to significant adverse health outcomes, including premature deaths, heart attacks, renal insufficiency and stroke. Screening for hypertension can identify adults at increased risk for cardiovascular disease due to high blood pressure. For ages 6-17 and 18 and older, standard blood pressure screening is included as part of the annual preventive examination. If it is determined that ambulatory blood pressure monitoring or home blood pressure monitoring is needed this will be allowed for members ages 18 and older.
Tobacco Counseling 2 quit attempt cycles per year. A quit attempt cycle includes 4 counseling visits and/or a 3-month supply of nicotine or non-nicotine replacement therapy.	Clinicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Pap Smear 1 per Calendar year	Screening for cervical cancer.
Contraception	Access to all Food and Drug Administration approved contraceptive methods requiring a prescription (formulary and generic medications), and patient education and counseling for reproductive capacity. No coverage for brochures or educational materials.
Breast Cancer Screening ▪ 1 between ages 35-39 ▪ 1 per Calendar year 40 years of age & older	1 screening mammography between ages 35 and 40 and then annually with or without clinical breast examination. Additional imaging and biopsies will be allowed for ages 40 and older.
Gestational Diabetes Screening 24+ weeks pregnant	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Breast Pump 1 pump per pregnancy	1 breast feeding pump (manual or electric) allowed per pregnancy purchased through a participating Home Medical Equipment Supplier.
Prostate Cancer Screening Per calendar year age 40 and older	Annual digital rectal examination and an annual prostate-specific antigen test for members age 40 and older.
Anxiety Screening	Recommend screening for anxiety disorders in adults, including pregnant and postpartum persons.

Scan the QR code to view the full list of preventive services or visit nd.blue/PreventiveCodingGuidelines

Find providers, virtual care options and care support programs using the Find Care tool located within BCBSND.me.

Scan the QR code to view the non-discrimination notice or visit nd.blue/non-discrimination-notice

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association.
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