BlueCross BlueShield Minnesota

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# Allina Health Allina First Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** **Beginning on or after 01/01/2019**
**Coverage for:** Single and family | **Plan Type:** PPO

**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, visit www.bluecrossmn.com/allinahealth or call 1-800-509-5310, and select option 1. 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 1-866-873-5943 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **In-Network and Extended Network**<br><br>**Single Plan:**<br>**$300** medical and drug deductible per person In-Network<br>**Family Plan:**<br>**$900** medical and drug per family deductible In-Network | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br><br>This plan has an embedded deductible. 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. In-Network Preventive care services are covered before you meet your deductible. | 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?** | No. | You don't have to meet "other" deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **In-Network and Extended Network**<br><br>**Single Plan:**<br>**$3,500** medical per person In-Network<br>**Family Plan:**<br>**$7,000** medical per family In-Network | 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. |

| | | |
|---|---|---|
| | **$1,000** prescription drug per individual and family per year for Allina First Network<br>**$2,000** prescription drug per individual and family per year for National Network | |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing 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.bluecrossmn.com/allinahealth or call 1-800-509-5310, and select option 1 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) | Extended Network | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10 copay/visit | $25 copay/visit | Not covered | None |
| | Specialist visit | 15% coinsurance | 30% coinsurance | Not covered | None |
| | Preventive care/screening/ immunization | No charge | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance deductible applies | 20% coinsurance deductible applies | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance deductible applies | 20% coinsurance deductible applies | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Extended Network | Out-of-Network Provider | |
| **If you need drugs to treat your illness or condition. A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Order Pharmacy dispenses prescription drugs through the U.S. Mail.** | Preferred generic drugs | Allina First Network<br>$5 copay/retail<br>$5 copay/mail order per 31-day supply<br>$5 copay/mail order per 93-day supply | National Network<br>$10 copay/retail<br>Mail order not covered | Not covered | Covers up to a 31-day supply (retail prescription); 32-93-day supply for mail order.<br><br>Mail order only available through Allina Health pharmacies.<br>. |
| | Preferred brand drugs | Allina First Network<br>25% coinsurance/retail<br>25% coinsurance/mail order | National Network<br>40% coinsurance/retail<br>Mail order not covered | Not covered | |
| | Non-preferred brand drugs | Allina First Network<br>50% coinsurance/retail<br>50% coinsurance/mail order | National Network<br>60% coinsurance/retail<br>Mail order not covered | Not covered | |
| | Specialty drugs | Available through Allina Health Pharmacy. Refer to applicable retail cost share | Not covered | Not covered | No coverage for services from Out-of-Network Providers.<br>If an Allina Health Pharmacy is unable to fill a specialty drug you must receive an override from the Allina Health Pharmacy to fill the drug with the Express Scripts specialty drug pharmacy, Accredo. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance<br>deductible applies | $250 copay per occurance; then<br>40% coinsurance<br>deductible applies | Not covered | None |
| | Physician/surgeon fees | 15% coinsurance<br>deductible applies | 15% coinsurance<br>deductible applies | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Extended Network | Out-of-Network Provider | |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance deductible applies | 25% coinsurance deductible applies | 25% coinsurance deductible applies | None |
| | Emergency medical transportation | 15% coinsurance deductible applies | 15% coinsurance deductible applies | 15% coinsurance deductible applies | |
| | Urgent care | 10% coinsurance | 20% coinsurance | 25% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance deductible applies | $250 copay per admission; then 40% coinsurance deductible applies | Not covered | For Mental Health/Substance use disorder: In-Network and Extended Network are 10% coinsurance deductible applies. |
| | Physician/surgeon fees | 15% coinsurance deductible applies | 15% coinsurance deductible applies | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copay/visit | $10 copay/visit | Not covered | Services for marriage/couples counseling are not covered. |
| | Inpatient services | 15% coinsurance deductible applies | 15% coinsurance deductible applies | Not covered | |
| **If you are pregnant** | Office visits | Prenatal Care: No charge Postnatal Care: No charge | Prenatal Care: No charge Postnatal Care: No charge | Not covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 15% coinsurance deductible applies | 15% coinsurance deductible applies | Not covered | |
| | Childbirth/delivery facility services | 10% coinsurance deductible applies | 40% coinsurance deductible applies | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 15% coinsurance | Not covered | 120 visits per person per calendar year, all networks |
| | Rehabilitation services | 10% coinsurance deductible applies for occupational therapy 10% coinsurance deductible applies for physical therapy | 20% coinsurance deductible applies for occupational therapy 20% coinsurance deductible applies for physical therapy | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Extended Network | Out-of-Network Provider | |
| | | 10% coinsurance deductible applies for speech therapy | 20% coinsurance deductible applies for speech therapy | | |
| | Habilitation services | 10% coinsurance deductible applies for occupational therapy<br><br>10% coinsurance deductible applies for physical therapy<br>10% coinsurance deductible applies for speech therapy | 20% coinsurance deductible applies for occupational therapy<br><br>20% coinsurance deductible applies for physical therapy<br>20% coinsurance deductible applies for speech therapy | Not covered | None |
| | Skilled nursing care | 15% coinsurance deductible applies | 15% coinsurance deductible applies | Not covered | None |
| | Durable medical equipment | 10% coinsurance deductible applies | 20% coinsurance deductible applies | Not covered | None |
| | Hospice services | 10% coinsurance deductible applies | 20% coinsurance deductible applies | Not covered | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | No coverage for these services. |
| | Children's dental check-up | Not covered | Not covered | Not covered | No coverage for these services. |

## 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.)** | | |
|---|---|---|
| • Cosmetic Surgery (except as specified in Plan benefits)<br>• Dental Care (except as specified in Plan benefits) | • Long-Term Care<br>• Private Duty Nursing | • Routine Foot Care<br>• Weight Loss Programs |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Acupuncture (except as specified in Plan benefits)<br>• Bariatric Surgery | • Chiropractic Care | • Hearing Aids<br>• Infertility treatment |

**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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other options to continue coverage are 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: your Claims Administrator by calling toll-free 1-866-873-5943 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 MNsure.

**Notice of Nondiscrimination Practices2**
***Effective July 18, 2016***
Both Allina Health and Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or gender. Allina Health and Blue Cross do not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Allina Health and Blue Cross provide resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.

- Language services such as qualified interpreters and information written in other languages are available free of charge to people whose primary language is not English.

If you need these services, contact Blue Cross at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross or Allina Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the applicable Grievance Coordinator:

- To Allina Health at
  Allina Health Grievance Coordinator
  P.O. Box 43
  Minneapolis, MN 55440-0043
  Phone: 612-262-0900
  Fax: 612-262-4370
  GrievanceCoordinator@allina.com
- To Blue Cross by email at: Civil.Rights.Coord@bluecrossmn.com
- To Blue Cross by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- To Blue Cross by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting Blue Cross or Allina Health at the numbers listed above.

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
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

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

## Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂိၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

*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 | $300 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 15% |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $40 |
| Coinsurance | $1,001 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,401** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 15% |

**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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $235 |
| Coinsurance | $1,123 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,713** |

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

| | |
|---|---|
| The plan's overall deductible | $300 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 15% |

**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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $273 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$573** |

Note: These numbers assume the patient does not participate in the plan's well-being program. If you participate in the plan's well-being program, you may be able to reduce your costs.



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