2019 Benefit Description
Select Health Savings Plan

Effective January 1, 2019

10198874, 75, 78, 79, 82, 83, 86, 87
V1.1.19
90964539.v2-3/18/19

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.

နမ္ပါကတိၤကညီကျိာ်ဒီး, တါကဟ့ဉ်နၤကျိာ်တါမၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, 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.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមែន 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'. Koji éí béésh bee hodíílnih áǫięęǫíǫąǫęią. TTY biniiyégo éí íáájį' béésh bee hodíílnih.

Notice of Nondiscrimination Practices

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The Claims Administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Claims Administrator provides 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 the Claims Administrator 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 the Claims Administrator 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 Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting the Claims Administrator 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 the Claims Administrator 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 phone 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.

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary, and remain subject to any requirements outlined in the Claims Administrator's medical policy and/or federal law.

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INTRODUCTION

This Document contains a summary of the Allina Select Health Savings Account (HSA) Medical and Prescription Drug Program (called the "Program" or "Plan" in this document) effective January 1, 2019. The Program is a component of the Allina Health Comprehensive Welfare Benefit Plan.

Coverage under this Program for eligible employees and dependents will begin as defined in the Allina Health Eligibility & Enrollment Booklet, which, along with this document, is the Summary Plan Description ("SPD") for your coverage.

All coverage for dependents and all references to dependents in this SPD are inapplicable for employee-only coverage.

This Program, financed and administered by Allina Health, is a self-insured medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the medical Claims Administrator and provides medical administrative services only. Express Scripts, Inc. is the pharmacy Claims Administrator and provides prescription drug administrative services only. The Claims Administrators do not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity. The eligibility and enrollment rules and other important rights you have as a participant in this Medical and Prescription Drug Program Option are contained in a separate booklet entitled "Allina Health Eligibility & Enrollment Booklet." To fully understand our benefits, you must carefully review this Benefit Description together with the Allina Health Eligibility & Enrollment Booklet.

Your Benefits

This SPD outlines the coverage under this Program. Please be certain to check the Benefit Chart section to identify covered benefits. You must also refer to the General Exclusions section to determine if services are not covered. The Glossary of Common Terms section defines terms used in this SPD. All services must be medically necessary to be covered, and even though certain non-covered services may be medically necessary, there is no coverage for them. If you have questions, call Customer Service using the telephone number on the back of your ID card. Providers are not beneficiaries under this Program.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed on the following page.

CUSTOMER SERVICE

Blue Cross Blue Shield of Minnesota Questions?	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters. Monday through Friday : 7am - 8pm United States Central Time Hours are subject to change without prior notice.
Blue Cross Blue Shield of Minnesota Customer Service Telephone Number	Claims Administrator: (651) 662-5859 or toll-free 1-800-509-5310, select prompt 1
Blue Cross Blue Shield of Minnesota Website	www.bluecrossmn.com/allinahealth
Medical Claims Administrator's Mailing Address	Claims review requests, and written inquiries may be mailed to the address below: Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164 Prior authorization requests should be mailed to the following address: Blue Cross and Blue Shield of Minnesota Utilization Management Department P.O. Box 64265 St. Paul, MN 55164
Stop-Smoking Support	Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583) or enroll at my BlueCross, the member center at the Claims Administrator's website. A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns. You will receive written materials and personalized help for up to 12 months.
Express Scripts Questions?	Express Scripts customer service representatives are available 24 hours a day, 7 days a week, to answer questions about your prescription drug coverage, claims as well as help you find a pharmacy.
Express Scripts Customer Service Telephone Number	Toll-free 1-800-509-5310, select prompt 2
Express Scripts Website	www.express-scripts.com/allinahealth
Pharmacy Claims Administrator's Mailing Address	Written claims for reimbursement should be submitted to: Express Scripts, Inc. Attn: Commercial Claims P.O. Box 14711 Lexington, KY 40512-4711

	Written clinical appeals should be mailed to the address below: Express Scripts, Inc. Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Written administrative appeals should be mailed to the address below: Express Scripts, Inc. Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
HelpCare Advisor Program Questions?	With the HelpCare Advisor program, you will have access to registered nurses, 24 hours a day, 7 days a week, who can help assist you with clinical triage, condition education, symptom support and disease case management. These advisors will also support you in navigating care.
HelpCare Advisor Program Customer Service Telephone Number	Toll-free 1-800-509-5310, select prompt 3

Choosing A Health Care Provider

You may choose any eligible provider of health services for the care you need. The Plan may pay higher benefits if you choose In-Network Providers. Generally you will receive the best benefit from your Plan when you receive care from In-Network Providers. For a list of In-Network Providers, visit www.bluecrossmn.com/allinahealth. ("Member Sign in" then "Find a Doctor"). This list is considered a component of your SPD. You may also contact Member Service at the telephone number listed on your member ID card.

The Plan features a large network of Participating Providers and each provider is an independent contractor and is not the Claims Administrator's agent.

If you want to know about the professional qualifications of a specific health care provider, call the provider or clinic directly.

In-Network Providers

Allina First Network Providers

All Allina Health and affiliated providers and facilities.

Extended Network Providers

Providers and facilities that contract to be in the Blue Cross Extended Network, not including the Allina First Network.

Out-of-Network Providers

The Plan provides benefits for covered services you receive from Out-of-Network Providers for ambulance, emergency room and urgent care services only.

Continuity of Care

If you are currently receiving care from a family practice or specialty physician who does not participate with the Claims Administrator, or if the relationship between your In-Network primary care clinic or physician and the Claims Administrator ends, rendering your clinic or provider nonparticipating with the Claims Administrator, and the termination was by the Claims Administrator and not for cause, you may request to continue to receive care from this physician for a special medical need or condition, for a reasonable period of time before transferring to an In-Network physician as required under the terms of your coverage with this Plan. The Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician certifies that your life expectancy is 180 days or less. The Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;

2. have a life-threatening mental or physical illness;

3. have a physical or mental health condition rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;

4. have a physical chronic condition in an acute phase or that is expected to last permanently;

5. are receiving culturally appropriate services from a provider with special expertise in delivering those services;

6. are receiving services from a provider that are delivered in a language other than English; or

7. continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits.

Call to speak with a Customer Service Representative for further information regarding continuity of care benefits.

Transition to In-Network Providers

At your request, the Claims Administrator will assist you in making the transition from an Out-of-Network Provider to an In-Network Provider. Please contact the Claims Administrator's customer service staff for a written description of the transition process, procedures, criteria, and guidelines.

Limitation

Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Claims Administrator's prior authorization requirements; and 2) provide the Claims Administrator with necessary medical information related to your care. Continuity of Care does not apply to services that are not covered under the Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

Provider Termination for Cause

If it is known that the Claims Administrator has terminated its relationship with your provider for cause, the Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an In-Network Provider must occur on or prior to the date of such termination for you to continue to receive In-Network benefits.

Payments Made in Error

Payments made in error or overpayments may be recovered by the Claims Administrator or ESI by any method allowed by law. Payment made for a specific service or erroneous payment shall not make the Claims Administrator, ESI or the Plan Administrator liable for further payment for the same service.

Liability for Health Care Expenses

Charges That Are Your Responsibility

In-Network Providers (Allina First Network and Blue Cross Extended Network)

When you use In-Network Providers for covered services, payment is based on the Allowed Amount. You are not required to pay for charges that exceed the Allowed Amount. You are required to pay the following amounts:

1. deductibles and coinsurance;

2. copays;

3. charges that exceed the benefit maximum; and

4. charges for services that are not covered.

Out-of-Network Providers

When you use Out-of-Network Participating Providers for covered services, payment is based on the Allowed Amount. Most Out-of-Network Participating Providers accept our payment based on the Allowed Amount and you may not be required to pay for charges that exceed the Allowed Amount. However, contact your Out-of-Network Participating Provider to verify if they accept our payment based on the Allowed Amount (to determine if you will have additional financial liability). In addition, you are required to pay the following amounts:

1. charges that exceed the Allowed Amount if the Out-of-Network Participating Provider does not accept our payment based on the Allowed Amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum level; and
5. charges for services that are not covered.

When you use Nonparticipating Providers for covered services, payment is still based on the Allowed Amount. However, because a Nonparticipating Provider had not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan, the Nonparticipating Provider is not obligated to accept the Allowed Amount as payment in full. This means that you may have substantial out-of-pocket expense when you use a Nonparticipating Provider. You are required to pay the following amounts:

1. charges that exceed the Allowed Amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum level; and
5. charges for services that are not covered, including services that the Claims Administrator determines are not covered based on claims coding guidelines.

Your claims may be reprocessed due to errors in the Allowed Amount paid to In-Network Providers, Out-of-Network Participating Providers, or Nonparticipating Providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

If you switch Medical Program benefits options mid-year, any amount accumulated toward the deductible or out-of-pocket maximum will be credited toward your new option's deductible and out-of-pocket maximum.

Inter-Plan Programs

Out-of-Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Claims Administrator's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's service area, you will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Nonparticipating Providers. The Claims Administrator's payment practices in both instances are described below.

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for (i) all dental care benefits that are not paid as medical claims/benefits, and (ii) those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Plan Administrator to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling the Claims Administrator's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you access covered health care services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed covered charges for your covered services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws that are not preempted by ERISA mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered health care services according to applicable law.

Special Cases: Value-Based Programs

<u>BlueCard Program</u>

If you receive covered health care services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments. Additional information is available from the Claims Administrator upon request.

Nonparticipating Providers Outside the Claims Administrator's Service Area

When covered health care services are provided outside of the Claims Administrator's service area by Nonparticipating Providers the Claims Administrator will pay based on the definition of "Allowed Amount" as set forth in the "Glossary of Common Terms" section of this SPD. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

BlueCard Worldwide® Program

Blue Cross Blue Shield Global Core

General Information

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a Network of inpatient, outpatient and professional providers, the Network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the providers and submit the Claims yourself to obtain reimbursement for these Services.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require you to pay for covered inpatient Services, except for your Deductibles, coinsurance, etc. In such cases, the Hospital will submit your Claims to the Blue Cross Blue Shield Global Core service center to initiate Claims processing. However, if you paid in full at the time of Service, you must submit a Claim to receive reimbursement for covered health care Services. You must contact the Claims Administrator to obtain Precertification for non-emergency inpatient Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a Claim to obtain reimbursement for covered health care Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core Claim form and send the Claim form with the provider's itemized bill(s) to the service center address on the form to initiate Claims processing. The Claim form is available from the Claims Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim, submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

General Provider Payment Methods

Participating Providers

The Claims Administrator contracts with a large majority of doctors, hospitals and clinics in Minnesota to be part of its network. Other Blue Cross and Blue Shield Plans contract with providers in their states as well. (Each Blue Cross and/or Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.) Each provider is an independent contractor and is not an agent or employee of the Claims Administrator, another Blue Cross and/or Blue Shield Plan, or the Blue Cross and Blue Shield Association. These health care providers are referred to as "Participating Providers." Most Participating Providers have agreed to accept as full payment (less deductibles, coinsurance and copays) an amount that the Claims Administrator has negotiated with its Participating Providers (the "Allowed Amount"). However, some Participating Providers in a small number of states may not be required to accept the Allowed Amount as payment in full for your specific plan and will be subject to the Nonparticipating Provider payment calculation noted below. The Claims Administrator recommends that you verify with your Participating Provider if they accept the Allowed Amount as payment in full. The Allowed Amount may vary from one provider to another for the same service.

Several methods are used to pay participating health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider's care to their patients and further based on claims savings that the provider may generate in the course of rendering cost effective care to its member patients. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider's compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others. Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payments.

- **Non-Institutional or Professional (i.e., doctor visits, office visits) Participating Provider Payments**

  - **Fee-for-Service** ─ Providers are paid for each service or bundle of services. Payment is based on the amount of the provider's billed charges.

  - **Discounted Fee-for-Service** ─ Providers are paid a portion of their billed charges for each service or bundle of services. Payment may be a percentage of the billed charge or it may be based on a fee schedule that is developed using a methodology similar to that used by the federal government to pay providers for Medicare services.

  - **Discounted Fee-for-Service, Withhold and Bonus Payments** ─ Providers are paid a portion of their billed charges for each service or bundle of services, and a portion (generally 5 - 20 percent) of the provider's payment is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the provider's care. In order to determine cost-effectiveness, a per member per month target is established. The target is established by using historical payment information to predict average costs. If the provider's costs are below this target, providers are eligible for a return of all or a portion of the withhold amount and may also qualify for an additional bonus payment.

  Payment for high cost cases and selected preventive and other services may be excluded from the discounted fee-for-service and withhold payment. When payment for these services is excluded, the provider is paid on a discounted fee-for-service basis, but no portion of the provider's payment is withheld.

- **Institutional (i.e., hospital and other facility) Participating Provider Payments**

  - **Inpatient Care**

    - **Payments for each Case (case rate)** ─ Providers are paid a fixed amount based upon the member's diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis ("outlier payment"). The method is similar to the payment methodology used by the federal government to pay providers for Medicare services.

    - **Payments for each Day (per diem)** ─ Providers are paid a fixed amount for each day the patient spends in the hospital or facility.

    - **Percentage of Billed Charges** ─ Providers are paid a percentage of the hospital's or facility's billed charges for inpatient or outpatient services, including home services.

  - **Outpatient Care**

    - **Payments for each Category of Services** ─ Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.

- **Payments for each Visit** – Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.

- **Payments for each Patient** – Providers are paid a fixed amount per patient per calendar year for certain categories of outpatient services.

Nonparticipating Providers

When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Nonparticipating Provider does not have any agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under Special Circumstances below), the Allowed Amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) 140% of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; or (3) pricing determined by another Blue Cross or Blue Shield plan. The payment option selected by the Claims Administrator may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator. The Allowed Amount for a Nonparticipating Provider is usually less than the Allowed Amount for a Participating Provider for the same service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the Plan and **you are responsible for paying the Nonparticipating Provider.** The only exception to this is stated in CLAIMS PROCEDURES, Claims Payment. This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

In determining the Allowed Amount for Nonparticipating Providers, the Claims Administrator makes no representations that the Allowed Amount is a usual, customary or reasonable charge from a provider. See the Allowed Amount definition for a more complete description of how payments will be calculated for services provided by Nonparticipating Providers.

- **Example of payment for Nonparticipating Providers**

  The following table illustrates the different out-of-pocket costs you may incur using Nonparticipating versus Participating Providers for most services. The example presumes that the member deductible has been satisfied and that the Plan covers 80 percent of the Allowed Amount for Participating Providers and 60 percent of the Allowed Amount for Nonparticipating Providers. It also presumes that the Allowed Amount for a Nonparticipating Provider will be less than for a Participating Provider. The difference in the Allowed Amount between a Participating Provider and Nonparticipating Provider could be more or less than the 40 percent difference in the following example.

	Participating Provider	Nonparticipating Provider
Provider charge:	$150	$150
Allowed Amount:	$100	$60
Claims Administrator pays:	$80 (80 percent of the Allowed Amount)	$36 (60 percent of the Allowed Amount)
Coinsurance member owes:	$20 (20 percent of the Allowed Amount)	$24 (40 percent of the Allowed Amount)
Difference up to billed charge member owes:	None (provider has agreed to write this off)	$90 ($150 minus $60)
Member pays:	$20	$114

  The Claims Administrator will, in most cases, pay the benefits for any covered health care services received from a Nonparticipating Provider directly to the member based on the Allowed Amounts and subject to the other applicable limitations in the Plan. An assignment of benefits from a member to a Nonparticipating Provider generally will not be recognized, except in the instance in which a custodial parent requests, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child.

- **Special Circumstances**

  There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care, such as hospital-based providers (e.g., anesthesiologists) who may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the Allowed Amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law. Please refer to Emergency Care for benefits.

Above is a general summary of the Plan's provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary.

Detailed information about payment allowances for services rendered by Nonparticipating Providers in particular is available at the Claims Administrator's website.

Recommendations by Health Care Providers

Referrals are not required. Your provider may suggest that you receive treatment from a specific provider or receive a specific treatment. Even though your provider may recommend or provide written authorization for a referral or certain services, the provider may be an Out-of-Network Provider or the recommended services may be covered at a lesser level of benefits or be specifically excluded. When these services are referred or recommended, a written authorization from your provider does not override any specific network requirements, notification requirements, or Plan benefits, limitations or exclusions.

Services that are Investigative or not Medically Necessary

Services or supplies that are investigative or not medically necessary are not covered. No payment of benefits will be allowed under this Plan including payments for services you have already received. The terms "investigative" and "medically necessary" are defined in the Glossary of Common Terms section.

Fraudulent Practices

Coverage for you or your dependents will be terminated (including retroactively) if you or your dependent engage in fraud of any type or intentional misrepresentation of material fact including, but not limited to: submitting fraudulent misstatements or omissions about your medical history or eligibility status in connection with enrollment; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another person not eligible for coverage under the Plan to use your or your dependent's coverage or to remain covered under the Plan. Allina Health System reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate your employment.

Medical Policy Committee and Medical Policies

The Claims Administrator's Medical Policy Committee develops medical policies that determine whether new or existing medical treatment should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered. From time to time new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the Claims Administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may be required. The Claims Administrator's medical policies may be found at the Claims Administrator's website and are hereby incorporated by reference.

In addition, Allina Health may, from time to time, determine that the Plan will cover procedures or services for "emerging technologies" (as defined by Allina Health). The criteria for any such procedure as developed by Allina Health, is available online at bluecrossmn.com/allinahealth or by calling Customer Service at (651) 662-5859 or toll free 1-800-509-5310, select prompt 1.

The Claims Administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your Plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification.

Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required.

Prior Authorization

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered. The Claims Administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the Claims Administrator's medical policy. The Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Claims Administrator's website or by calling Customer Service and is considered part of the SPD.

For **inpatient hospital/facility services**, all In-Network Providers and Extended Network Providers are required to obtain prior authorization for you. You are responsible for obtaining prior authorization when receiving **inpatient hospital/facility services** from Nonparticipating Providers.

For **outpatient hospital/facility services or professional services**, Minnesota In-Network Providers and Minnesota Extended Network Participating Providers are required to obtain prior authorization for you. You are required to obtain prior authorization when you use Extended Network Participating Providers outside Minnesota and any provider outside Minnesota. However, some of these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you.

Minnesota Participating Providers who do not obtain prior authorization for you are responsible for the charges if the services are found to be not medically necessary. If it is found, at the point the claim from a Participating Provider outside Minnesota or Nonparticipating Provider is processed, that services were not medically necessary, you are liable for all of the charges. The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

The Claims Administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. Refer to the Customer Service section for the telephone number and appropriate mailing address for prior authorization requests.

Preadmission Notification

Preadmission notification is a process whereby the provider or you inform the Claims Administrator that you will be admitted for inpatient hospitalization services. This notice is required at least 2 days in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

Minnesota In-Network Providers and Minnesota Extended Network Providers are required to provide preadmission notification for you. **If those providers do not provide preadmission notification for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you are going to receive nonemergency inpatient care from a Nonparticipating Provider in Minnesota or any provider outside Minnesota, you are required to provide preadmission notification to the Claims Administrator. Some of these providers may provide preadmission notification for you. Verify with your provider if this is a service they will perform for you or not. **You may also be required to obtain prior authorization for services or procedures while you are an inpatient, e.g., if you are having elective surgery while an inpatient at a Nonparticipating Provider. Refer to Prior Authorization in this section to determine if you, or your**

provider, are responsible for obtaining any required prior authorization(s). Minnesota Participating Providers who do not obtain preadmission notification for you are responsible for the charges, if the admission is found to be not medically necessary. If preadmission notification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.

Preadmission notification is required for the following admissions/facilities:

1. Hospital acute care admissions (medical and behavioral); and

2. Residential behavioral health treatment facilities.

Penalty Provision

If the Claims Administrator is not notified of your admission a penalty will apply. The Claims Administrator reduces the Allowed Amount for the admission by 20 percent. This means that without preadmission notification you will pay a greater portion of the charges. The penalty applies when the Claims Administrator is not notified of your admission to Nonparticipating Providers.

To provide preadmission notification, call the customer service telephone number provided in the Customer Service section. They will direct your call.

Preadmission Certification

Preadmission certification is a process to provide a review and determination related to a specific request for care or services. Preadmission certification includes concurrent/length-of-stay review for inpatient admissions. This notice is required in advance of being admitted for inpatient care for any type of nonemergency admission and for partial hospitalization.

All Minnesota In-Network Providers and Minnesota Extended Network Providers are required to provide preadmission certification for you. **If those providers do not provide preadmission certification for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you are going to receive nonemergency inpatient care from a Nonparticipating Provider in Minnesota or any provider outside Minnesota, you are required to provide preadmission certification to the Claims Administrator. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you or not. **You may also be required to obtain prior authorization for services or procedures while you are an inpatient, e.g., if you are having elective surgery while an inpatient at a Nonparticipating Provider. Refer to Prior Authorization in this section to determine if you, or your provider, are responsible for obtaining any required prior authorization(s). Minnesota Participating Providers who do not obtain preadmission certification for you are responsible for the charges if the admission is found to be not medically necessary. If preadmission certification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

1. Acute rehabilitation (ACR) admissions;

2. Long-term acute care (LTAC) admissions; and

3. Skilled nursing facility admissions.

To provide preadmission certification, call the Customer Service telephone number provided in the Customer Service section. They will direct your call.

Emergency Admission Notification

In order to avoid liability for charges that are not considered medically necessary, you are required to provide emergency admission notification to the Claims Administrator as soon as reasonably possible after an admission for pregnancy, medical emergency, or injury that occurred within 48 hours of the admission.

Minnesota In-Network Providers and Minnesota Extended Network Providers are required to provide emergency admission notification for you. **If those providers do not provide preadmission for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you receive care from a Nonparticipating Provider in Minnesota or any provider outside Minnesota, you are required to provide emergency admission notification to the Claims Administrator within 48 hours of the admission or as soon as reasonably possible after admission for pregnancy, medical emergency, or injury. Some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you or not. **If emergency admission notification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.**

To provide emergency admission notification, call the customer service telephone number provided in the Customer Service section. They will direct your call.

MEDICAL CLAIMS PROCEDURES

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this Plan. The claims procedures described in this SPD are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of medical benefits under this Plan. If the Claims Administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this Plan, no benefits will be payable under this Plan. All claims and questions regarding claims should be directed to the Claims Administrator. For claims procedures applicable to prescription drugs, see the Prescription Drug Claims Procedures section later in this SPD.

Types of Claims

A “claim” is any request for a Plan benefit made in accordance with these claims procedures. You become a “claimant” when you make a request for a Plan benefit in accordance with these claims procedures. There are four types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-service Claim

A “Pre-service Claim” is any request for a Plan benefit where the Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then it is not a "Pre-service Claim." The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Urgent Care Claim

An “Urgent Care Claim” is a special type of Pre-service Claim. An “Urgent Care Claim” is any Pre-service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-service Claims could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Claims Administrator will determine whether a Pre-service Claim involves urgent care, provided that, if a physician with knowledge of the claimant’s medical condition determines that a claim involves urgent care, the claim will be treated as an Urgent Care Claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the Claims Administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A “Concurrent Care Claim" arises when the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Claims Administrator has approved. If the Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claim

A “Post-service Claim” is any request for a Plan benefit that is not a Pre-service Claim or an Urgent Care Claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an Urgent Care Claim. If the urgency subsides, it may be re-characterized as a Pre-service Claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the Claims Administrator.

Filing Claims

Except for Urgent Care Claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for Plan benefits to the Claims Administrator. A claimant is not responsible for submitting claims for services received from In-Network or Out-of-Network Participating Providers. These providers will submit claims directly to the local Blue Cross and Blue Shield Plan on the claimant's behalf and payment will be made directly to these providers. If a claimant receives services from Nonparticipating Providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf of the claimant, the claimant should send the claims to the Claims Administrator. The necessary forms may be obtained by contacting the Claims Administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Urgent Care Claims

An Urgent Care Claim may be submitted to the Claims Administrator by telephone at (651) 662-5859 or toll-free 1-800-509-5310, select prompt 1.

Pre-service Claims

A Pre-service Claim (including a Concurrent Care Claim that is also a Pre-service Claim) is considered filed when the request for approval of treatment or services is made and received by the Claims Administrator.

Post-service Claims

A Post-service Claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly-Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed Pre-service Claim, the Claims Administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed Urgent Care Claim, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

Timeframes for Deciding Claims

Urgent Care Claims

The Claims Administrator will decide an Urgent Care Claim and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-service Claims

The Claims Administrator will decide a Pre-service Claim and notify you of the decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the Claims Administrator will decide the claim and notify you of the decision within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for Pre-service, Urgent Care, or Post-service Claims.

Concurrent Care Reduction or Early Termination

The Claims Administrator's decision to reduce or terminate an approved course of treatment is an adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The Claims Administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The Claims Administrator will decide a Post-service Claim and notify you of any adverse decision within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the Claims Administrator is not able to decide a Pre-service or Post-service Claim and notify you of the decision within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the Claims Administrator's control that justify the extension and the date by which the Claims Administrator expects to render a decision. No extension of time is permitted for Urgent Care Claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The Claims Administrator will decide the claim and notify you of the decision as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a Pre-service or Post-service Claim is incomplete, the Claims Administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the Claims Administrator. The Claims Administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision within the time period required by the Department of Labor claims procedure regulations.

Notification of Initial Benefit Decision

The Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, benefits, or (b) a failure to provide or make payment (in whole or in part) for a benefit; or (c) a rescission of coverage. The Claims Administrator will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether or not the decision is adverse. The Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Appeals of Adverse Benefit Determinations

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The Claims Administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, or a rescission of coverage;

2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;

3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;

4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

5. The Claims Administrator will give no deference to the initial benefit decision;

6. The Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;

7. The Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;

8. The Claims Administrator will provide you, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Claims Administrator did not rely upon their advice;

9. The Claims Administrator will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances; and information regarding any voluntary appeals offered by the Plan;

10. The Claims Administrator will provide you any new evidence considered, generated, or relied upon free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond prior to making a final benefit determination;

11. The Claims Administrator will provide you any new rationale for an adverse benefit determination prior to making a final benefit determination and with enough time before making a final determination so that you will have an opportunity to respond; and

12. The Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Claims Administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the Claims Administrator by telephone at (651) 662-5859 or toll-free 1-800-509-5310, select prompt 1. The Claims Administrator will transmit all necessary information, including the Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

Timeframes for Deciding Appeals

Urgent Care Claims

The Claims Administrator will decide the appeal of an Urgent Care Claim and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The Claims Administrator will decide the appeal of a Pre-service Claim and notify you of the decision within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-service Claims

The Claims Administrator will decide the appeal of a Post-service Claim and notify you of any adverse decision within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for Pre-service, Urgent Care, or Post-service Claims described above, as appropriate to the request.

Notification of Appeal Decision

The Claims Administrator will provide the claimant with written notice of the appeal decision. The notification will include the content required by law.

The Claims Administrator may provide you with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. Unless these procedures are deemed to be exhausted, the decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures (with the exception of a voluntary internal appeal and external review) must be exhausted before any legal action is commenced (unless the claims procedures are deemed to have been exhausted).**

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

Voluntary Internal Appeal

A voluntary internal appeal is available to a claimant receiving an adverse decision on a Pre-service or Post-Service Claim appeal if the claimant files a voluntary appeal within 60 days following receipt of the adverse Pre-service or Post-Service Claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Claims Administrator. The Claims Administrator will provide the claimant with written notice of the voluntary appeal decision within 30 days of receipt of the appeal. For more information on the voluntary appeals process, contact the Claims Administrator.

Special Rules for Claims Related to Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If your coverage is going to be rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for post-service claim denials.

External Review

Standard External Review

If your claim relates to medical judgment or rescission, you may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

    a. you are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

    b. the adverse benefit determination or the final adverse benefit determination is based on medical judgment or rescission;

    c. you have exhausted the Plan's internal appeal process (unless exhaustion is not required); and

    d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the Claims Administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. Within 1 business day after completion of the preliminary review, the Claims Administrator will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

3. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

   The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

   The Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

   The IRO will review all of the information and documents timely received and is not bound by the Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

   a. your medical records;

   b. the attending health care professional's recommendation;

   c. reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you, or your treating provider;

   d. the terms of the Plan;

   e. evidence-based practice guidelines;

   f. any applicable clinical review criteria developed and used by the Claims Administrator; and

   g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

   The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:

   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When the Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by the Claims Administrator's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to you and the Plan.

General Rules

- The exhaustion of the claims procedures (with the exception of the voluntary appeal and external claim review process) is mandatory for resolving every claim and dispute arising under this Plan. In any legal action brought after you have exhausted the administrative remedies, all determinations made by the Claims Administrator, Allina Health or other fiduciary, shall be afforded the maximum deference permitted by law.
- If you file your claim within the required time and complete the entire claims procedure (except for the voluntary appeal and external review), any lawsuit must be commenced within six months after the claim-and-review procedure is complete. In any event, you must commence the suit within two years after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the Plan provides; or the date you knew or reasonably should have known of the principal facts on which your claim is based.
- Your initial claim, any request for review of an adverse benefit determination, and any request for external appeal must be made in writing, except for requests for review of adverse benefit determinations relating to urgent care claims, which may also be made orally.
- You must follow the claims procedures contained in this SPD carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (the Claims Administrator or Allina Health may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent care claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
- You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. You will also be allowed to review the claim file and present evidence and testimony as part of the internal claims process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by the Claims Administrator.
- Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible, except in the absence of your legal capacity, within 12 months (or 90 days for administrative requests relating to eligibility or enrollment) after the earlier of the date on which: (1) you were denied benefits; (2) you received benefits at a different level than you believed the Plan provides; or (3) you knew or reasonably should have known of the principal facts on which your claim is based.

Additional Provisions

Authorized Representative

A claimant may appoint an “authorized representative” to act on his or her behalf with respect to a claim or an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Claims Administrator. However, in connection with an Urgent Care Claim, the Claims Administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the Claims Administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the Claims Administrator or Plan Administrator.

Claims Payment

When a claimant uses In-Network or Out-of-Network Participating Providers, the Plan pays the provider. When a claimant uses a Nonparticipating Provider, the Plan pays the claimant. A claimant may not assign his or her benefits to a Nonparticipating Provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Plan pay a Nonparticipating Provider for covered services for a child. When the Plan pays the provider at the request of the custodial parent, the Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Claims Administrator.

The Plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury’s Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third Party Beneficiaries

The Plan benefits described in this Summary Plan Description are intended solely for the benefit of you and your covered dependents. No person who is not a Plan participant or dependent of a Plan participant may bring a legal or equitable claim or cause of action pursuant to this Summary Plan Description as an intended or third party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give the Claims Administrator needed information about the care that they provide to them. This includes information about care received prior to the claimant’s enrollment with the Claims Administrator where necessary. The Claims Administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant’s failure to provide authorization or requested information may result in denial of the claimant’s claim.

Right of Examination

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant’s failure to comply with this request may result in denial of the claimant’s claim.

BENEFIT CHART

This section lists covered services and the benefits the Plan pays. All benefit payments are based on the Allowed Amount. Coverage is subject to all other terms and conditions of this Summary Plan Description and must be medically necessary.

Benefit Features, Limitations, and Maximums

Networks

- Allina First Network Providers
- Extended Network Providers (Aware Network Providers and BlueCard PPO Network Providers)

Benefit Features	Your Liability
Deductible	
• Allina First Network and Extended Network Providers combined	$1,400 per person per calendar year $2,800 per family per calendar year
• Out-of-Network Providers	$3,000 per person per calendar year $6,000 per family per calendar year

The amounts accumulated toward the Single Coverage deductible do not apply to the Family Coverage deductible. These are separate deductible options.

The amounts accumulated toward the Deductible are applied to services provided by the Allina First Network, Extended Network and Out-of-Network Providers.

Amounts accumulated toward the Allina First Network and Extended Network Deductible also accumulate toward the Out-of-Network Deductible. When the Allina First Network and Extended Network Deductible is satisfied, covered services from Allina First Network and Extended Network Providers will be paid at the covered percentage.

Amounts accumulated toward the Out-of-Network Deductible also accumulate toward the Allina First Network and Extended Network Deductible. When the Out-of-Network Deductible is satisfied, we consider the Allina First Network and Extended Network Provider Deductible satisfied and covered services from all providers will be paid at the covered percentage.

The annual deductible and out of pocket maximum on your high deductible health plan will be indexed, as described in IRS guidance.

Benefit Features	Limitations and Maximums
Out-of-Pocket Maximums	
• Allina First Network and Extended Network Providers combined	$4,000 per person per calendar year $8,000 per family per calendar year
• Out-of-Network Providers	$7,000 per person per calendar year

The amounts accumulated toward the Out-of-Pocket Maximum are applied to services provided by the Allina First Network, Extended Network and Out-of-Network Providers.

Amounts accumulated toward the Allina First Network and Extended Network Out-of-Pocket Maximum also accumulate toward the Out-of-Network Out-of-Pocket Maximum. When the Allina First Network and Extended Network Out-of-Pocket Maximum is satisfied, covered services from Allina First Network and Extended Network Providers will be paid at the covered percentage.

Amounts accumulated toward the Out-of-Network Out-of-Pocket Maximum also accumulate toward the Allina First Network and Extended Network Out-of-Pocket Maximum. When the Out-of-Network Out-of-Pocket Maximum is satisfied, we consider the Allina First Network and Extended Network Out-of-Pocket Maximum satisfied and covered services from all providers will be paid at the covered percentage.

The following items are applied toward the out-of-pocket maximum:
1. medical coinsurance;
2. medical deductibles;
3. prescription drug coinsurance
4. prescription drug copay
5. prescription drug deductible

Calendar Year Maximum	
• Infertility medical services For all infertility treatment for all charges and networks combined, including facility take home prescription drugs and injectable prescription drugs administered by a health care professional.	$5,000 per person per calendar year
• Infertility prescription drugs	$5,000 per person per calendar year
Lifetime Maximum	
• Palliative Care	$4,000 per person
• Total benefits paid to all other providers combined	Unlimited

Benefit Descriptions

Refer to the following pages for a more detailed description of Plan benefits.

Ambulance and Medical Transportation

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the condition • Medically necessary, prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse	85% after you pay the deductible.	85% after you pay the deductible.	85% after you pay the deductible.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- If the Claims Administrator determines air ambulance was not medically necessary but ground ambulance would have been, the Plan pays up to the Allowed Amount for medically necessary ground ambulance.

NOT COVERED:

- transportation services that are not medically necessary for basic or advanced life support
- transportation services that are mainly for your convenience including costs related to transportation (to a facility that is not the nearest medical facility equipped to treat the condition)
- please refer to the General Exclusions section

Bariatric Surgery

The Plan Covers:	In-Network Providers	Out-of-Network Providers
• Medically necessary **inpatient hospital/facility** services for bariatric surgery from admission to discharge ▪ room and board and general nursing care ▪ intensive care and other special care units ▪ operating, recovery, and treatment rooms ▪ anesthesia ▪ prescription drugs and supplies used during a covered hospital stay ▪ lab and diagnostic imaging • Medically necessary **outpatient hospital/facility** services for bariatric surgery: ▪ scheduled surgery/anesthesia ▪ lab and diagnostic imaging ▪ all other eligible outpatient hospital care related to bariatric surgery provided on the day of surgery	**Members age 18 and older:** 90% after you pay the deductible when you use **Allina Designated Bariatric Network**. **Members age 17 and younger:** 90% after you pay deductible when you use **Allina First Network Providers**.	**Members age 18 and older:** 80% after you pay the Extended Network deductible when you use **Blue Distinction Centers for Bariatric Surgery**. When you use a Provider that is not in the Allina Designated Bariatric Network or a Blue Distinction Centers for Bariatric Surgery, there is **NO COVERAGE.** **Members age 17 and younger:** 80% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount when you use an **Extended Network Provider**. When you use an Out-of-Network Provider, there is **NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **Members age 17 and younger have direct access to In-Network Providers for the highest level of benefits.**
- **For professional services related to eligible bariatric surgery services, refer to Professional Services and/or Convenience Care.**
- Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association.
- As technology changes, the covered bariatric surgery procedures will be subject to modifications in the form of additions or deletions when appropriate.
- All requests for prior authorization must be submitted in writing to:

  Blue Cross and Blue Shield of Minnesota
  Utilization Management Department
  P.O. Box 64265
  St. Paul, MN 55164

- For a list of Blue Distinction Centers for Bariatric Surgery call Customer Service or visit the Claims Administrator's website.
- For pre-operative and post-operative bariatric services, refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.
- Out-of-Network Participating Provider means a hospital or other institution that has a contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan but is not in the Blue Distinction Network.

NOT COVERED:

- please refer to the General Exclusions section

Behavioral Health: Mental Health Services

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ individual/group/family therapy (office/in-home mental health services) ▪ neuro-psychological examinations • Professional health care charges for services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluations ▪ observation beds ▪ family therapy • Inpatient health care professional charges	Services in a physician's office**:** 90% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	Services in a physician's office**:** 80% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based Intensive Outpatient Programs (IOP) ▪ all eligible inpatient services ▪ emergency holds	90% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.

- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds" as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Coverage is provided for diagnosable mental health conditions, including autism and eating disorders.
- For lab and diagnostic imaging services billed by a health care professional refer to Professional Services and/or Convenience Care.
- For home health related services, refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Benefits provided for autism treatment and intensive behavioral therapy programs for the treatment of autism spectrum disorder include, but are not limited to: intensive early intervention behavioral therapy services (EIBTS); intensive behavioral intervention (IBI); and Lovaas Therapy.

NOT COVERED:

- services for mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services
- services for marital/couples counseling
- services for or related to marital/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
- educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
- services for the treatment of learning disabilities
- therapeutic day care and therapeutic camp services
- hippotherapy (equine movement therapy)
- please refer to the General Exclusions section

Behavioral Health: Chemical Health Services

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ family therapy ▪ opioid treatment • Outpatient hospital/outpatient behavioral health treatment facility charges for services including Intensive Outpatient Programs (IOP) and related aftercare services • Inpatient health care professional charges	Services in a physician's office**:** 90% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	Services in a physician's office**:** 80% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Inpatient hospital/residential behavioral health treatment facility charges	90% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- Admissions that qualify as "emergency holds", as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- For lab and diagnostic imaging services billed by a health care professional refer to Professional Services and/or Convenience Care.
- For home health related services, refer to Home Health Care.

NOT COVERED:

- services for substance abuse or addictions not listed in the most recent editions of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter care, and lodging programs
- halfway house services

- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
- please refer to the General Exclusions section

Chiropractic Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Office visits from a Doctor of Chiropractic • Manipulations • Therapies • Other chiropractic services	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the chiropractor's time.

NOT COVERED:

- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized therapy to treat the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Dental Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth • Oral surgery and anesthesia for: ▪ removal of impacted teeth ▪ removal of a tooth root without removal of the whole tooth • Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: ▪ orthognathic surgery ▪ related orthodontia • Tooth extraction when due to a medical diagnosis (see NOTES)	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Services for the treatment of ectodermal dysplasia including: ▪ orthodontia ▪ bone grafts ▪ dental implants ▪ dentures ▪ bridgework	90% after you pay the deductible.	80% after you pay the deductible.	80% after you pay the deductible.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- All of the above mentioned benefits are subject to medical necessity and eligibility of the proposed treatment. Treatment must occur while you are covered under this Plan.
- Tooth extraction coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of jaw, cysts and lesions.
- Accident-related dental services must be started within six (6) months of the injury and completed within 2 years from the date of injury. Coverage for treatment and/or restoration is limited to re-implantation of original sound and healthy natural teeth, crowns, fillings and bridges.
- The Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- For medical services, refer to Hospital Inpatient, Hospital Outpatient, Professional Services and/or Convenience Care, etc.
- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound and healthy natural tooth.

NOT COVERED:

- all orthodontia, except as specified in the Benefit Chart
- dental services to treat an injury from biting or chewing
- dentures, regardless of the cause or the condition, and any associated services and/or charges, including bone grafts
- dental implants and any associated services and/or charges, except as specified in the Benefit Chart
- replacement of a damaged dental bridge from an accident-related injury
- osteotomies and other procedures associated with the fitting of dentures or dental implants, except as specified in the Benefit Chart
- root canal therapy
- accident-related dental services started more than six (6) months after the injury or occurring more than 2 years after the date of initial injury
- services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, except as specified in the Benefit Chart
- services to treat bruxism, including dental splints
- please refer to the General Exclusions section

Emergency Room

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Outpatient hospital/facility emergency room charges • Outpatient health care professional charges • Take home prescription drugs	75% after you pay the deductible.	75% after you pay the deductible.	75% after you pay the deductible.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- In true emergency situations where you must be treated immediately, **go to your nearest hospital emergency provider, or call 911 or your area's emergency number**. When determining if a situation is a medical emergency, the Claims Administrator will take into consideration presenting symptoms including, but not limited to severe pain, and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- Eligible services you receive from Out-of-Network Providers apply to the In-Network deductible and out-of-pocket maximum.
- For inpatient services, refer to Hospital Inpatient and Professional Services and/or Convenience Care.
- For urgent care visits, refer to Urgent Care.

NOT COVERED:

- please refer to the General Exclusions section

Home Health Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to: ▪ intermittent skilled nursing care in your home by a: - licensed registered nurse - licensed practical nurse ▪ services provided by a medical technologist ▪ services provided by a licensed dietician ▪ services provided by a respiratory therapist ▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services of a home health aide or masters level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees ▪ use of appliances that are owned or rented by the home health agency ▪ home infusion therapy ▪ home health care following early maternity discharge ▪ palliative care ▪ prescription drugs dispensed by the home health agency	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **Home health care and home infusion therapy are limited to a combined maximum benefit of 120 visits per person per calendar year.**
- Eligible intermittent skilled nursing services provided by a licensed registered nurse or licensed practical nurse who are employees of a Medicare approved or other preapproved home health care agency consists of up to two (2) consecutive hours per date of service.
- The one (1) home health care visit following early maternity discharge does not apply to the 120 visit maximum.

- For supplies and durable medical equipment billed by a Home Health Agency, refer to Medical Equipment, Prosthetics, and Supplies.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The home health care visit following early maternity discharge must be provided by a registered nurse and include, but is not limited to: parent education; assistance and training in breast and bottle feeding; and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and her newborn child.

NOT COVERED:

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care– refer to Skilled Nursing Care – Extended Hours, Skilled Nursing Care – Intermittent Hours, and Skilled Care in the Glossary of Common Terms section
- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- home infusion services or supplies not specifically listed as covered services
- nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- services that do not involve direct patient contact, such as delivery charges and recordkeeping
- investigative or non-FDA approved drugs, except as required by law
- please refer to the General Exclusions section

Hospice Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice, including: ▪ routine home care ▪ continuous home care ▪ inpatient respite care ▪ general inpatient care	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Benefits are restricted to terminally ill patients with a terminal condition (i.e. life expectancy of six (6) months or less). The patient's primary physician must certify in writing a life expectancy of six (6) months or less. Hospice benefits begin on the date of admission to a hospice program with prior approval.
- **Inpatient respite care is for the relief of the patient's primary caregiver and is limited to a maximum of five (5) consecutive days at a time up to a maximum of 30 days during the episode of hospice care.**
- General inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Medical care services unrelated to the terminal condition are covered, but are separate from the hospice benefit.

NOT COVERED:

- room and board expenses in a residential hospice facility
- please refer to the General Exclusions section

Hospital Inpatient

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Room and board and general nursing care • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Prescription drugs and supplies used during a covered hospital stay • Take home prescription drugs • Lab and diagnostic imaging • Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Magnetic esophageal ring surgery services (see NOTES)	90% after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **The Plan covers medically necessary gender identity disorder. Gender identity disorder is a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. Sex reassignment refers to the process through which an individual diagnosed with gender identity disorder seeks to change his/her biological body through hormonal therapy, sex transformation surgery, or both.**
- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- For health education for the management of chronic health problems, refer to Professional Services and/or Convenience Care.
- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major transplant or other kinds of transplants, refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- The Plan covers anesthesia and inpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.

NOT COVERED:

- communication services provided on an outpatient basis or in the home
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care– refer to Skilled Nursing Care – Extended Hours, Skilled Nursing Care – Intermittent Hours, and Skilled Care in the Glossary of Common Terms section
- please refer to the General Exclusions section

Hospital Outpatient

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Scheduled surgery/anesthesia • Radiation and chemotherapy • Kidney dialysis • Respiratory therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Take home prescription drugs • All other outpatient hospital care	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Resiliency training (see NOTES) • Magnetic esophageal ring surgery services (see NOTES)	90% after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
• Palliative care	85% after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
• Lab and diagnostic imaging, except as listed below	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Lab screening for cotinine alkaloid	100%	100%	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **The Plan covers medically necessary gender identity disorder. Gender identity disorder is a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. Sex reassignment refers to the process through which an individual diagnosed with gender identity disorder seeks to change his/her biological body through hormonal therapy, sex transformation surgery, or both.**
- **Palliative care is limited to a maximum benefit of $4,000 per person per lifetime.**
- **Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program.**
- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- For health education for the management of chronic health problems, refer to Professional Services and/or Convenience Care.
- For urgent care visits, refer to Urgent Care.

- For physical, occupational and speech therapy services, refer to Physical Therapy, Occupational Therapy, Speech Therapy.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable) from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided.
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.
- The Plan covers anesthesia and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

NOT COVERED:

- please refer to the General Exclusions section

Infertility Treatment

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Artificial insemination (AI) and intrauterine insemination (IUI) procedures • Related services and supplies • Injectable drugs administered by a health care professional • Facility take home prescription drugs	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Non-investigative assisted reproductive technologies (ART) when ordered by a board-certified or board-eligible reproductive endocrinology physician, and furnished in a medical facility approved by the Claims Administrator as a provider of ART services and supplies. No benefits are paid at facilities other than those approved by the Claims Administrator. No benefits are paid for services the Claims Administrator determines are not medically necessary.	85% after you pay the deductible.	85% after you pay the deductible.	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **Benefits are subject to a calendar year maximum of $5,000 per person for all infertility treatment for all charges and networks combined, including facility take home prescription drugs and injectable prescription drugs administered by a health care professional.**
- **Benefits for assisted reproductive technologies (ART) are limited to 2 embryos per cycle per person.**
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- A cycle is defined as one (1) partial or complete fertilization attempt extending through the implantation phase only.

NOT COVERED:

- services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- donor ova or sperm
- services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- pharmacy billed prescription drugs
- services and prescription drugs for or related to gender selection services
- please refer to the General Exclusions section

Maternity

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Maternity education for pregnancy, birth and parenting classes as defined by Allina Health System (see NOTES)	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Health care professional and hospital/facility charges for: ▪ delivery ▪ postpartum care	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.	For the level of coverage, see Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.
• Family planning services	100%	100%	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **For prenatal care benefits, refer to Preventive Care.**
- **For more information or to register for pregnancy, birth or parenting classes contact Allina Health Class Registration toll free at 1-866-904-9962. For questions about reimbursement call Blue Cross Customer Service toll free at 1-800-509-5310 and select prompt 1.**
- Refer to the Eligibility section to determine when baby's coverage will begin.
- Group health plans such as this Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may under federal law, require that a provider obtain authorization from the Claims Administrator for prescribing a length of stay greater than 48 hours (or 96 hours).
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- The Plan covers one (1) home health care visit within four (4) days of discharge from the hospital if either the mother or the newborn child is confined for a period less than the 48 hours (or 96 hours) mentioned above. See Home Health Care.

NOT COVERED:

- health care professional charges for deliveries in the home
- services for or related to adoption fees
- services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- childbirth classes
- services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- services for or related to elective cesarean (C-) section for the purpose of convenience
- please refer to the General Exclusions section

Medical Equipment, Prosthetics, and Supplies

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, and hospital beds • Devices for habilitative and rehabilitative services • Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings • Blood, blood plasma, and blood clotting factors • Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes • Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician • Corrective lenses for aphakia • Hearing aids for children age 18 and younger who have a hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years. • Cochlear implants • Non-investigative bone conductive hearing devices • Scalp/cranial hair prostheses (wigs) provided hair loss is due to alopecia areata. • Custom foot orthoses only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet.	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

• Ostomy Supplies • Diabetic supplies, including: ▪ cotton balls; ▪ alcohol swabs; and ▪ other diabetic supplies. • Insulin pumps, glucometers and related equipment and devices	100% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Durable medical equipment is covered up to the Allowed Amount to rent or buy the item. Allowable rental charges are limited to the Allowed Amount to buy the item.
- Coverage for durable medical equipment will not be excluded solely because it is used outside the home.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- For hearing aid exam services, refer to Professional Services and/or Convenience Care.

NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart (with the exception of elemental formula for infants with a verified protein allergy which requires prior authorization).
- personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary
- services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; hot tubs; whirlpools; and incontinence pads or pants
- modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
- blood pressure monitoring devices
- communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
- services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
- duplicate equipment, prosthetics, or supplies
- replacement of properly functioning durable medical equipment
- foot orthoses, except as specified in the Benefit Chart
- scalp/cranial hair prosthesis (wigs), for any diagnosis other than alopecia areata
- services for or related to hearing aids or devices, except as specified in the Benefit Chart
- non-prescription supplies such as alcohol, cotton balls and alcohol swabs
- devices for maintenance services
- please refer to the General Exclusions section

Physical Therapy, Occupational Therapy, Speech Therapy

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Habilitative and rehabilitative office visits from a physical therapist or occupational therapist • Therapies from a physical therapist or occupational therapist • Office visits from a speech or language pathologist • Therapies from a speech or language pathologist	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Office visits from a physician	Services in a physician's office 90% after you pay the deductible.	Services in a physician's office 80% after you pay the deductible	Services in a physician's office 60% after you pay the deductible

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- For lab and diagnostic imaging services billed by a health care professional, refer to Professional Services and/or Convenience Care.
- For hospital/facility charges, refer to Hospital Inpatient and Hospital Outpatient.
- Office visits may include a physical therapy evaluation or re-evaluation, occupational therapy evaluation or re-evaluation, or speech or swallowing evaluation.

NOT COVERED:

- services primarily educational in nature, except as specified in the Benefit Chart
- services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return either to their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider
- services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); or educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc.; and all related material and products for these programs
- services for or related to therapeutic massage
- physical, occupational, and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider
- services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable amount of time, unless they are medically necessary and are part of specialized therapy for the member's condition
- maintenance services
- custodial care
- please refer to the General Exclusions section

Preventive Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Preventive care services from professionals, outpatient hospitals/facilities, and medical equipment suppliers included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) for: ▪ adults ▪ infants and children ▪ prenatal care	100%	100%	**NO COVERAGE.**

NOTES:

- Preventive care services will comply with state and federal statutes and regulations (e.g., cancer screening services). The Plan will cover new preventative care recommendations and guidelines at 100% as soon as administratively feasible following the date the recommendations or guidelines are issued, but in no event later than January 1 of the year following the year in which the recommendation or guideline was issued.
- For more information regarding preventive care services covered by the Plan, please visit the Claims Administrator's website at https://www.bluecrossmn.com/healthy/public/portalcomponents/PublicContentServlet?contentId=P11GA_11972782 or contact Customer Service.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable), and you are not responsible for charges that exceed the Allowed Amount from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided:
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.
- The Plan covers the purchase of a manual breast pump.
- The Plan covers surgical implants and tubal ligation for elective female sterilization which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the full range of preventive contraceptive methods and for patient education/counseling for women of reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Refer to Prescription Drugs and Insulin for pharmacy drug coverage.
- Services for removal and complications related to female contraceptive drugs, devices, and services for women of reproductive capacity may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.

- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.
- The Plan covers “child health supervision services,” which is pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory service appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to 18 as defined by Standards of Child Health Care issued by the American Academy of Pediatrics.
- Prenatal care is the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

NOT COVERED:

- services you receive from an Out-of-Network Provider
- services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
- services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining/maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request
- educational classes or programs, except educational classes or programs required by federal law
- services for or related to lenses, frames, and contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except where eligible under Medical Equipment, Prosthetics, and Supplies
- treatment, services, or supplies which are investigative or not medically necessary
- please refer to the General Exclusions section

Professional Services and/or Convenience Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Office visits for illness (for services other than the office visit charge, see below) • Diabetes outpatient self-management training and education, including medical nutrition therapy • Inpatient hospital/facility visits during a covered admission • Outpatient hospital/facility visits • Anesthesia by a provider other than the operating, delivering, or assisting provider • Surgery, including circumcision and sterilization (see NOTES) • Assistant surgeon • Kidney and cornea transplants • Injectable drugs administered by a health care professional • Therapeutic acupuncture	Services in a physician's office: 90% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	Services in a physician's office: 80% after you pay the deductible. Services in a hospital/facility: 85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• E-Visit • Retail health clinic, include lab and diagnostic imaging • Telephone consults physician with patient	95% after you pay the deductible.	90% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Inpatient services for an inpatient hospital facility stay within 24 hours of an emergency department visit for the same illness	85% after you pay the deductible.	85% after you pay the deductible.	85% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Lab and diagnostic imaging, except as listed below • Outpatient allergy testing • Hearing aid exams/fittings/adjustments for children age 18 and younger.	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

• Outpatient allergy serum and injections	100% after you pay the deductible.	100% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Resiliency training (see NOTES)	90% after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
• Advanced care planning in a physician's office • Comprehensive medication review program (see NOTES) • Health education for the management of chronic health problems including: ▪ early pregnancy ▪ family planning services ▪ nutrition ▪ breast self-exam ▪ cholesterol ▪ instructions regarding medication	100%	100%	**NO COVERAGE.**
• Outpatient sleep studies	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Bariatric surgery to correct morbid obesity including: ▪ anesthesia ▪ assistant surgeon	85% after you pay the deductible.	85% after you pay the deductible.	**NO COVERAGE.**
• Palliative care (see NOTES) • Magnetic esophageal ring surgery services (see NOTES)	85% after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
• Lab screening for cotinine alkaloid	100%	100%	**NO COVERAGE.**

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- **The Plan covers medically necessary gender identity disorder. Gender identity disorder is a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender. Sex reassignment refers to the process through which an individual diagnosed with gender identity disorder seeks to change his/her biological body through hormonal therapy, sex transformation surgery, or both.**
- **Palliative care is limited to a maximum benefit of $4,000 per person per lifetime.**
- **Resiliency training is limited to one assessment and one training program per person per lifetime, with payment conditioned upon completion of the program.**

- **If you meet the criteria for coverage, you may qualify for the Comprehensive Medication Review program/Medication Therapy Disease Management Program. The Program covers private consultations with a designated clinical pharmacist. If you take several medications, have diabetes, or coronary artery disease, you may be eligible for the program. To find out if you qualify or for more information about the Program and available providers, contact Allina Health at PharmacyCMR@allina.com.**
- **Coverage for magnetic esophageal ring surgery services is limited to services provided by Surgical Specialists of MN and Abbott Northwestern Hospital.**
- When Retail Health Clinic lab and diagnostic imaging services are sent out to be read by an independent Out-of-Network provider, the charges will be paid at the Retail Health Clinic level of coverage.
- If more than one (1) surgical procedure is performed during the same operative session, the Plan covers the surgical procedures based on the Allowed Amount for each procedure. The Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable), and you are not responsible for charges that exceed the Allowed Amount from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided:
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.
- The Plan covers certain physician services for preventive care. Refer to Preventive Care.
- Specific surgical implants and tubal ligation for elective female sterilization are covered under preventive care. Refer to Preventive Care.
- For kidney transplants performed in conjunction with an eligible major transplant, refer to Transplant Coverage.
- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form 2728 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the Claims Administrator. Please verify with your provider that form 2728 has been completed and submitted.
- For urgent care visits, refer to Urgent Care.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement.
- The Plan covers certain patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- An E-Visit is a patient initiated, limited on-line evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- A retail health clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- The Plan covers hearing aid exams/fittings/adjustments for children age 18 and younger.
- For self-injectable prescription medications/drugs, refer to Prescription Drugs and Insulin, except as provided in the Claims Administrator's medical policy.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- separate charges for pre-operative and post-operative care for surgery
- internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit
- provider initiated email communications
- cosmetic surgery to repair a physical defect
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- physician dispensed self-administered prescription drugs for infertility treatment
- please refer to the General Exclusions section

Reconstructive Surgery

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part • Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician • Elimination or maximum feasible treatment of port wine stains	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.	For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Professional Services and/or Convenience Care.
• Treatment of cleft lip and palate when services are scheduled or initiated prior to the member turning age 19 including dental implants	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Under the Federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.
- Congenital means present at birth.
- Bone grafting for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.

NOT COVERED:

- repair of scars and blemishes on skin surfaces
- dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts
- dental implants and any associated services and/or charges, except as specified in the Benefit Chart
- please refer to the General Exclusions section

Skilled Nursing Facility

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Skilled care ordered by a physician and eligible under Medicare guidelines • Room and board • General nursing care • Prescription drugs used during a covered admission • Take home prescription drugs • Physical, occupational, and speech therapy	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.

NOT COVERED:

- charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
- treatment, services or supplies which are not medically necessary
- please refer to the General Exclusions section

Transplant Coverage

The Plan Covers:	Allina Designated Transplant Providers	Out-of-Network Providers
The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures: • Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures • Autologous bone marrow transplant and peripheral stem cell transplant procedures • Heart • Heart – lung • Kidney – pancreas transplant performed simultaneously (SPK) • Liver – deceased donor and living donor • Lung – single or double • Pancreas transplant – deceased donor and living donor segmental ▪ Pancreas Transplant Alone (PTA) ▪ Simultaneous Pancreas – Kidney transplant (SPK) ▪ Pancreas transplant After Kidney transplant (PAK) • Small-bowel and small-bowel/liver	90% of the Transplant Payment Allowance after you pay the deductible for the transplant admission. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.	**Blue Distinction Centers for Transplant (BDCT) Providers:** 80% of the Transplant Payment Allowance after you pay the deductible for the transplant admission, plus you pay any charges billed to you that exceed the Allowed Amount. For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage. **Non-Blue Distinction Centers for Transplant (BDCT) Provider:** 60% of the Transplant Payment Allowance after you pay the deductible for the transplant admission. In addition, you are responsible for all charges that exceed the Transplant Payment Allowance.

NOTES:

- Kidney transplants when not performed in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Professional Services and/or Convenience Care.
- **Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.**
- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form 2728 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your Provider must send the completed form to CMS and the Claims Administrator. Please verify with your Provider that form 2728 has been completed and submitted.

NOT COVERED:

- travel expenses
- travel expenses for a kidney donor
- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
- kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
- services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart
- services, supplies, drugs, and aftercare for or related to artificial or nonhuman organ implants
- services, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered
- services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs, and aftercare for or related to bone marrow and peripheral stem cell support procedures that are considered investigative or not medically necessary
- living donor organ and/or tissue transplants unless otherwise specified in this Summary Plan Description
- transplantation of animal organs and/or tissue
- please refer to the General Exclusions section

DEFINITIONS:

- **BDCT Provider** means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures. These providers have been selected to participate in this nationwide transplant network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Once selected for participation, institutions are re-evaluated annually to insure that they continue to meet the established criteria for participation in this network.
- **Participating Transplant Provider** means a hospital or other institution that has a contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures.
- **Transplant Payment Allowance** means the amount the Plan pays for covered services to a BDCT Provider or a Participating Transplant Provider for services related to human organ, bone marrow, cord blood and peripheral stem cell transplant procedures in the agreement with that provider.

*An association of independent Blue Cross and Blue Shield Plans.

Urgent Care

The Plan Covers:	Allina First Network Providers	Extended Network Providers	Out-of-Network Providers
• Professional services for urgent care in a physician's office, including lab and diagnostic imaging	85% after you pay the deductible.	85% after you pay the deductible.	75% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Hospital/facility charges urgent care	90% after you pay the deductible.	80% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.
• Facility charges for lab and diagnostic imaging • Professional services for urgent care in an outpatient facility, including lab and diagnostic imaging	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.

NOT COVERED:

- please refer to the General Exclusions section

GENERAL EXCLUSIONS

The Plan does not pay for:

1. Treatment, services, or supplies which are not medically necessary.
2. Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.
3. Treatments, procedures, or services or drugs which are provided when you are not covered under this Plan.
4. Any portion of a charge for a covered service or supply that exceeds the Allowed Amount, except as specified in the Benefit Chart.
5. Services that are provided without charge, including services of the clergy.
6. Charges for services: (a) for which a charge would not have been made in the absence of insurance or medical plan coverage; or, (b) which the covered person in not legally obligated to pay; and, (c) from providers who waive copayment, deductible, and coinsurance payments by the covered person.
7. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.
8. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost sharing amount (including, for example, deductibles, copayments, and coinsurance) described in this Plan.
9. Services for or related to therapeutic acupuncture, except for the treatment of chronic pain or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
10. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a worker's compensation claim.
11. Services that are rendered to a covered person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits as required under the Plan.
12. Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
13. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
14. Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.
15. Services to treat illnesses/injuries that occur while on military duty and are recognized by the Veterans Administration as services related to service-connected illnesses/injuries.
16. Services for dependents if you have employee-only coverage.
17. Services that are prohibited by law or regulation.
18. Services which are not within the scope of licensure or certification of a provider.
19. Charges for furnishing medical records or reports and associated delivery charges.
20. Ambulance transportation services that are not medically necessary for basic or advanced life support.

21. Transportation services, including ambulance services that are mainly for your convenience.

22. Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. The Plan will cover eligible medically necessary ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A, are not covered under the Plan, and you will be responsible for those costs).

23. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.

24. Services for or related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).*

25. Services or confinements ordered by a court or law enforcement officer that are not medically necessary.

26. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs.

27. Services for or related to room and board for foster care, group homes, incarceration, shelter care, and lodging programs, halfway house services, and skills training.

28. Services for or related to marital/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.

29. Services for or related to marital/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder.

30. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).

31. Services for or related to substance abuse or addictions not listed in the most recent edition of the *International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).*

32. Services for or related to substance abuse interventions (defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition).

33. Services for or related to therapeutic massage.

34. Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts.

35. Dental implants and associated services and/or charges, except as specified in the Benefit Chart.

36. Services for or related to the replacement of a damaged dental bridge from an accident-related injury.

37. Services for or related to root canal therapy.

38. Services to treat bruxism, including dental splints.

39. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.

40. Room and board expenses in a residential hospice facility.

41. Admission for diagnostic tests that can be performed on an outpatient basis.

42. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

43. Personal comfort items, such as telephone, television, etc.

44. Communication services provided on an outpatient basis or in the home.

45. Services and prescription drugs for or related to gender selection.

46. Services and prescription drugs for or related to gender identity disorder, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling, unless medically necessary as determined by the Claims Administrator prior to receipt of services.

47. Services for or related to reversal of sterilization.

48. Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities.

49. Services for or related to adoption fees and childbirth classes.

50. Services for or related to elective cesarean (C-) section for the purpose of convenience.

51. Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.

52. Donor ova or sperm.

53. Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart.

54. Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart.

55. Services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants.

56. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.

57. Blood pressure monitoring devices.

58. Foot orthoses, except as specified in the Benefit Chart.

59. Scalp/cranial hair prostheses (wigs), for any diagnosis other than alopecia areata.

60. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.

61. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.

62. Services for or related to hearing aids or devices, except as specified in the Benefit Chart.

63. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.

64. Services primarily educational in nature, except as specified in the Benefit Chart.

65. Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.

66. Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.

67. Services for or related to health clubs and spas.

68. Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the member's condition.

69. Maintenance services.

70. Custodial care.

71. Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other nonmedical services normally provided in an educational setting); or forms of nonmedical self- care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs.

72. Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.

73. Services for or related to the repair of scars and blemishes on skin surfaces.

74. Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.

75. Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart.

76. Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.

77. Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment; services for or related to homeopathy or chelation therapy that the Claims Administrator determines is not medically necessary.

78. Services for or related to gene therapy as a treatment for inherited or acquired disorders.

79. Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.

80. Autopsies.

81. Charges for failure to keep scheduled visits.

82. Charges for giving injections that can be self-administered.

83. Services provided during an e-visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications, educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit, except as specified in the Benefit Chart

84. Provider initiated e-mail communications.

85. Services related to transcranial magnetic stimulation therapy.

86. Facsimile transmission communications between members and providers.

87. Services provided by naturopathic providers.

88. Services for or related to smoking cessation program fees and/or supplies, except as specified in the Stop-Smoking Support section.

89. Services for or related to preventive medical evaluations for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.

90. Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.

91. Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.

92. Services for or related to fetal tissue transplantation.

BENEFIT CHART FOR PRESCRIPTION DRUGS

This section lists covered services and the benefits the Plan pays for prescription drugs. The prescription drug benefit is administered by Express Scripts.

Benefit Features, Limitations, and Maximums

Networks

- Allina First Network (Allina Health Pharmacy)
- National Network (Express Scripts Network Pharmacies), which does not include Walgreens.

Benefit Features	Your Liability
Deductible	
The deductibles under the Allina First Network, National Network and Out-of-Network are combined.	
• Allina First Network	$1,400 per person per calendar year $2,800 per family per calendar year
• National Network	$1,400 per person per calendar year $2,800 per family per calendar year
• Out-of-Network	$3,000 per person per calendar year $6,000 per family per calendar year
Benefit Features	**Limitations and Maximums**
Out-of-Pocket Maximums	
The out-of-pocket limits under the Allina First Network, National Network and Out-of-Network are combined.	
• Allina First Network	$4,000 per person per calendar year $8,000 per family per calendar year
• National Network	$4,000 per person per calendar year $8,000 per family per calendar year
• Out-of-Network	$7,000 per person per calendar year

The following items are applied toward the out-of-pocket maximum:
1. prescription drug coinsurance
2. prescription drug copay
3. prescription drug deductible
4. medical coinsurance;
5. medical deductible;
6. diabetic supplies

The following items are NOT applied toward the out-of-pocket maximum:
1. excess charges for purchasing brand-name prescription drugs when there is a generic drug equivalent available
2. special dietary treatment for Phenylketonuria (PKU)
3. amino acid based elemental formula
4. charges for non-covered items

Refer to the following pages for a more detailed description of Prescription Drug benefits.

Prescription Drugs

The Plan Covers:	Allina First Network	National Network	Out-of-Network Providers
• Retail (up to 31-day supply)			
▪ Generic	$5 copay after you pay the deductible.	$10 copay after you pay the deductible.	60% after you pay the deductible.
▪ Preferred-brand name	75% after you pay the deductible.	60% after you pay the deductible.	60% after you pay the deductible.
▪ Non-Preferred	50% after you pay the deductible.	40% after you pay the deductible.	40% after you pay the deductible.
• Mail order (up to 93-day supply)			
▪ Generic	$5 copay after you pay the deductible.	**NO COVERAGE.**	**NO COVERAGE.**
▪ Preferred-brand name	75% after you pay the deductible.		
▪ Non-Preferred	50% after you pay the deductible.		
• Insulin	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible.
• Insulin Pump	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Insulin Pump Supplies and Equipment	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Diabetic Supplies and Equipment	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Ostomy Supplies	100%	80% after you pay the deductible.	60% after you pay the deductible.
• Drugs for Treatment of sexual dysfunction (Non-Essential Benefit)			
▪ Generic	85% after you pay the deductible.	85% after you pay the deductible.	60% after you pay the deductible.
▪ Preferred-brand name	75% after you pay the deductible.	75% after you pay the deductible.	60% after you pay the deductible.
▪ Non-Preferred	50% after you pay the deductible.	50% after you pay the deductible.	40% after you pay the deductible.
• Tobacco cessation products	100%	**NO COVERAGE.**	**NO COVERAGE.**
• Specialty drugs (31 day supply)			

▪ Drugs for the treatment of growth deficiency ▪ Drugs for treatment of infertility (Non-Essential Benefit) ▪ All Other Specialty drugs	80% after you pay the deductible. 75% after you pay the deductible. See Allina First Network - Retail.	**NO COVERAGE.**	**NO COVERAGE.**

NOTES:

- The prior authorization program monitors certain prescription drugs and their costs. You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs that require prior authorization.
- Specialty drugs are limited to drugs on the specialty drug list and must be obtained from an Allina Health Pharmacy.
- 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.
- For the treatment of sexual dysfunction/erectile dysfunction, all drugs are subject to quantity limits. Call the Express Scripts customer service at 1-800-509-5310 to learn about the limits.
- Tobacco cessation products must be prescribed by a licensed provider.
- Unless otherwise specified in the Prescription Drug section, you may receive up to a 31-day supply per prescription. All drugs are subject to Express Scripts utilization review process and quantity limits. In addition, certain drugs may be subject to quantity limits applied as part of the trial program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time.
- Drugs for the treatment of infertility are subject to a $5,000 maximum benefit per calendar year.
- If there is a generic equivalent and you request the brand-name drug, you must pay the copay for the brand name drug plus the amount that the cost of the brand-name drug exceeds the cost of the generic drug.
- The Plan covers certain prescription female contraceptive drugs which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA) effective no later than January 1 of the year following the year the recommendation was issued.
- Present your medical ID card to ensure proper submission of your claim. Pharmacy information is on the front of the medical ID card.

Specialty Drugs

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

You are required to obtain specialty drugs from an Allina Health Pharmacy.

Mail Order

Benefit-eligible employees enrolled in an Allina Health medical plan have a lower co-pays when using an Allina Health Pharmacy. Online ordering through MyChart is convenient and fast, especially for maintenance medications. You may order online through MyChart at www.allinahealth.org/mychart and pick them up in person at one of the many Allina Health Pharmacy locations, or have them mailed to you at no additional cost.

While a 93 day supply of your medication is available at any Allina Health Pharmacy location, the primary site for employee mail order is the Allina Health Ritchie Pharmacy.

The first time you use the mail order pharmacy benefit, you must call the Allina Health Ritchie Pharmacy to ensure they have all your up-to-date information.

Your prescription will be processed and mailed to the designated address within four business days free of any shipping charges.

Prescriptions may be ordered using the following methods:

- online request through MyChart (For new prescriptions, the original prescription must be submitted using one of the methods below.)
- electronically sent or faxed from your physician's office
- telephone submission by your physician
- hard copy prescription dropped off or mailed in to the pharmacy

Locating a Network Pharmacy

To locate an Allina Health Pharmacy, visit www.allinahealth.org/pharmacy or call Express Scripts at 1-800-509-5310, and select prompt 2.

To locate an Express Scripts National Network pharmacy anywhere in the country, visit www.express-scripts.com/allinahealth or call Express Scripts at 1-800-509-5310, and select prompt 2. **The Express Scripts National Network does not include Walgreens.**

Formulary Information

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the Plan, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to www.express-scripts.com/allinahealth. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to your health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by you. If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost sharing structure. Absent such approval, if you select drugs excluded from the Formulary you will be required to pay the full cost of the drug without any reimbursement under the Plan. If your physician believes that an excluded drug meets the requirements described above, he or she should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g., prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Clinical Programs

The Prescription Drug Plan uses pharmacy management programs for safety, quality, and cost reasons. The programs include Step Therapy, Prior Authorization and Quantity Management. **The Express Scripts National Network does not include Walgreens.**

Step Therapy

Step Therapy is a program for people who take prescription drugs regularly to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure. In Step Therapy, the covered drugs are organized in a series of "steps," with the doctor approving and writing prescriptions.

- The program usually starts with generic drugs in the "first step." Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by your plan have been proven to be effective in treating many medical conditions. This first step allows patients to begin or continue treatment with safe, effective prescription drugs that are also affordable.
- The doctor is consulted and then approves prescriptions in writing based on the list of Step Therapy drugs covered by the plan. For instance, the doctor must write your new prescription when patients change from a second-step drug to a first-step drug.

You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drugs subject to Step Therapy.

Prior Authorizations

The prior authorization program monitors certain prescription drugs and their costs so you can get the right drug at the right cost. If a patient is prescribed a certain medicine, that drug may need a "prior authorization". You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for current a list of prescription drugs that require prior authorization.

Prior Authorization also ensures that covered drugs are used for treating medical problems rather than for other purposes. A prior authorization is used to make sure the medicine is covered for the medical condition but not for cosmetic purposes. For more information on requesting a prior authorization, see the *Prescription Drug Claims Procedures* section below.

Drug Quantity Management

The Drug Quantity Management program is designed to support safe, effective, and economic use of drugs while providing you access to quality care. Express Scripts' clinicians maintain a list of medication quantity limits, which are based upon FDA-approved dosing guidelines and medical literature.

Should patients need additional quantities of medications; criteria have been established for overrides in selected situations.

Drugs Excluded

The following list of excluded drugs is not all inclusive and is subject to change at any time and without notice. You may call Express Scripts customer service at 1-800-509-5310, and select prompt 2 or visit www.express-scripts.com/allinahealth for a current list of prescription drug excluded under the Plan.

- Non-Federal Legend Drugs
- Federal Legend Non-Drugs
- Non Federal Legend Non-Drugs
- Investigational Drugs
- Std Rx/OTC Equivalents
- Diagnostics
- Homeopathic Drugs
- Abortifacients Mifeprex
- Nutritional Supplements and Combo Nutritional Products
- Infant Formulas – Rx & OTC
- Enteral Nutritional Medications
- [OTC and Legend] Smoking Deterrents unless purchased from Allina Health Pharmacy
- Respigam and Synagis
- Cosmetic Drugs - ALL (examples include drugs for Hypopigmentation, Renova, Vaniqa)
- Hair Growth Stimulants and other products indicated only for cosmetic use
- Biologicals, Allergy Sera, Blood Products
- Vitamins (OTC)
- Peak Flow Meter - (OTC & Rx)
- Injectable Medications administered at Physician's Office

PRESCRIPTION DRUG CLAIMS PROCEDURES

Claims

All claims are treated as filed on the date they are received. Either you or your authorized representative may file a claim for Prescription Drug Plan benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Prescription Drug Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

You have the right to request that a prescription drug be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative claims coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

Requesting Prior Authorization

To request an initial clinical coverage review, also called prior authorization (also called initial clinical coverage review), your participating provider submits the request electronically. Information about electronic options can be found at www.express-scripts.com/PA.

To request an initial administrative coverage review, you or your representative must submit the request in writing, using a Benefit Coverage Request Form available by calling the ESI customer service phone number on the back of your prescription card. Complete the form and mail or fax it to:

Express Scripts
ATTN: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 877 328-9660.

If you use a participating pharmacy, and have your ID card on file with that pharmacy, your claim will be submitted for you automatically. In the event you need to submit a claim yourself, you may obtain a claim form by calling ESI Member Services at 1-800-509-5310 or online at www.express-scripts.com. Send your completed form to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Timeframes for Deciding Claims

Urgent Care Claims

ESI will decide an Urgent Care Claim (as defined in the Medical Claims Procedures section) and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. If you or your provider believes your situation is urgent, the expedited review must be requested by your provider by phone at 1-800-753-2851.

Pre-service Claims/Prior Authorization/Clinical Coverage Review

ESI will decide a Pre-service Claim (as defined in the Medical Claims Procedures section) and notify you of the decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Post-Service Claims

Claims must be filed no later than 12 months after the date of receipt of the treatment or product to which the claim relates. ESI will decide a Post-service Claim (as defined in the Medical Claims Procedures section) and notify you of any adverse decision within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

You may voluntarily agree to extend the timeframes described above. In addition, if ESI is not able to decide a Pre-service or Post-service Claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided you are notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond ESI's control that justify the extension and the date by which ESI expects to render a decision. No extension of time is permitted for Urgent Care Claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an Urgent Care Claim is incomplete, ESI will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. ESI will decide the claim and notify you of the decision as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a Pre-service or Post-service Claim is incomplete, ESI will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. You will have 45 days from the date you received the notice to provide the missing information. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to ESI. ESI will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision within the time period required by the Department of Labor claims procedure regulations.

Notification of Initial Benefit Decision

If your claim is denied in whole or in part, you will receive a written notice of the denial directly from ESI. The notice will explain the reason for the denial and the review procedures. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of benefits, or (b) a failure to provide or make payment (in whole or in part) for a benefit, or (c) a rescission of coverage. ESI will provide the claimant written notice of the decision on a Pre-service or Urgent Care Claim whether or not the decision is adverse. ESI may provide the claimant with oral notice of an adverse benefit determination on an Urgent Care Claim, but written notice will be furnished no later than three (3) days after the oral notice.

Appeals

Appeal Procedures

ESI will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment for a benefit, a denial of coverage, or a rescission of coverage;

2. A claimant must file an appeal within 180 days to ESI at the appropriate address below following receipt of a notice of an adverse benefit determination;

3. The following information must be included with the request for appeal:

    - Claimant name;
    - Claimant member ID;
    - Claimant phone number;
    - The drug name for which benefit coverage has been denied;
    - Brief description of why you disagree with the initial adverse benefit determination; and
    - Any additional information that may be relevant to the appeal, including provider statements/letters, bills or any other documents.

4. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;

5. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;

6. ESI will give no deference to the initial benefit decision;

7. ESI will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;

8. ESI will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;

9. ESI will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances; and information regarding any external review offered by the Plan;

10. ESI will provide you any new evidence considered, generated, or relied upon free of charge as soon as possible and with enough time before a final determination is required to be provided to you (as described above) so that you will have an opportunity to respond prior to making a final benefit determination;

11. ESI will provide you any new rationale for an adverse benefit determination prior to making a final benefit determination and with enough time before making a final determination so that you will have an opportunity to respond; and

12. ESI will provide required notices in a culturally and linguistically appropriate manner.

Filing of Appeals

Appeal requests should be sent to:

Clinical coverage appeal requests:	Administrative coverage appeal requests:

Express Scripts
ATTN: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 1-877-852-4070

Express Scripts
ATTN: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6588
Fax: 1-877-328-9660

The appeal is reviewed by a pharmacist to determine if the request has any additional information, or if it is the same information in the initial request.

- If new information provided: If there is an approval granted based on the new information provided, an override or payment is issued and a letter is mailed to you. If the new information still results in a denial, a denial reconsideration letter is mailed with further appeal rights with Express Scripts' address.
- If no new information provided from original denial: The appeal is sent to MCMC for review. MCMC is not affiliated with Express Scripts and it independently reviews previously denied services. MCMC reviews the case information and provides Express Scripts with the decision, and a letter is sent to you based on determination. If the appeal is approved, the necessary overrides are entered into the Express Scripts' system. If the appeal is denied, MCMC sends a denial letter to you explaining further appeal rights.

Urgent Care Appeals

An urgent care appeal may be submitted to ESI using the appropriate telephone or fax number listed below. ESI will transmit all necessary information, including ESI's determination on review, by telephone, fax, or other available similar methods.

Clinical Coverage Review and Claim Appeal Requests: Phone: 1-800-753-2851, Fax: 1-877-852-4070

Administrative Coverage Review Appeal Requests: Phone: 1-800-946-3979, Fax: 1-877-328-9660

Timeframes for Deciding Appeal

Urgent Care Claims

ESI will decide the appeal of an Urgent Care Claim and notify you of the decision as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

ESI or MCMC (for 2nd level appeals) will decide the appeal of a Pre-service Claim and notify you of the decision no later than 15 days after receipt of the written request for review.

Post-service Claims

ESI or MCMC (for 2nd level appeals) will decide the appeal of a Post-service Claim and notify you of the decision no later than 30 days after receipt of the written request for review.

Notification of Appeal Decision

ESI will provide the claimant with written notice of the appeal decision. The notification will include the information required by law.

ESI may provide you with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. The decision by ESI on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures (with the exception of the voluntary second level appeal and an external review) must be exhausted before any legal action is commenced.**

Following notification of a non-urgent coverage or Claim appeal decision, you may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). In urgent care situations, there is only one level of appeal prior to an external review.

Special Rules for Claims Related to Rescissions

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If your coverage is going to be rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that can be appealed according to the rules described above for Post-service Claim denials.

MCMC then reviews the case and provides Express Scripts with a determination. If the appeal is denied, MCMC sends a denial letter to you explaining further appeal rights.

Voluntary Second Level Appeal

If you are not satisfied with the decision of your initial appeal, you may request a second level appeal to ESI by mail or fax using the appropriate address listed above, based on the type of initial appeal you requested (except that voluntary appeal is not available for urgent care claims). You must request a second level appeal within 90 days of your receipt of an adverse initial appeal decision.

The following information must be included with the request for a second level appeal:

- Claimant name;
- Claimant member ID;
- Claimant phone number;
- The drug name for which benefit coverage has been denied;
- Brief description of why you disagree with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including provider statements/letters, bills or any other documents.

ESI will forward your request for a second level appeal to MCMC. If approved, the information is entered into the Express Scripts system. If the determination results in denial, the denial is entered into the Express Scripts system, and a final denial is mailed to you.
The procedure and timeframes for deciding a second level appeal, are the same as those for initial appeals. Please refer to those specific sections for additional information on the appeals process.

Voluntary External Review

If you are not satisfied with the final internal review decision on your first level appeal, and your claim involved medical judgment or rescission, including determinations involving treatment that is considered experimental or investigational, you may submit a request for an external review. Generally, all internal appeal rights must be exhausted prior to requesting an external review. To submit a request for an external review, you must mail or fax your request to:

MCMC LLC
ATTN: Express Scripts Appeal Program
300 Crown Colony Drive. Suite 203
Quincy, MA 02169-0929
Phone: 1-617-375-7700 ext. 28253
Fax: 1-617-375-7683

For claims involving medical judgment or rescission, you may file a request for an external review within four (4) months after the date of receipt of a notice of a final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, MCMC will complete a preliminary review of the request to determine whether:

    a. you are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

    b. the final adverse benefit determination is based on medical judgment or rescission;

    c. you have exhausted the Plan's internal appeal process other than any voluntary appeal (unless exhaustion is not required); and

    d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, MCMC will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.

2. Within 1 business day after completion of the preliminary review, MCMC will notify you in writing regarding whether your claim is eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

3. MCMC will assign an accredited independent review organization (IRO) to conduct the external review.

    The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

    MCMC will provide documents and any information considered in making the final internal adverse benefit determination to the IRO.

    The IRO will review all of the information and documents timely received and is not bound by ESI's or MCMC's prior determination. The IRO may consider the following in reaching a decision:

    a. your medical records;

    b. the attending health care professional's recommendation;

    c. reports from appropriate health care professionals and other documents submitted by ESI or MCMC, you, or your treating provider;

    d. the terms of your Plan;

    e. evidence-based practice guidelines;

    f. any applicable clinical review criteria developed and used by ESI or MCMC; and

    g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

    The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:

   a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, ESI will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

3. When ESI determines that your request is eligible for external review an IRO will be assigned. ESI will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

   The IRO must consider the information or documents provided and is not bound by ESI's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to you and the Plan.

General Rules

- The exhaustion of the claims procedures (with the exception of the voluntary second level appeal and external review process) is mandatory for resolving every claim and dispute arising under this Plan. In any legal action brought after you have exhausted the administrative remedies, all determinations made by ESI, Allina Health or other fiduciary, shall be afforded the maximum deference permitted by law.
- If you file your claim within the required time and complete the entire claims procedure (except for the voluntary second level appeal and external review), any lawsuit must be commenced within six months after the claim-and-review procedure is complete. In any event, you must commence the suit within two years after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the Plan provides; or the date you knew or reasonably should have known of the principal facts on which your claim is based.
- Your initial claim, any request for review of an adverse benefit determination, and any request for external appeal must be made in writing, except for requests for review of adverse benefit determinations relating to urgent care claims, which may also be made orally.
- You must follow the claims procedures contained in this SPD carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (ESI or Allina Health may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent care claims a health care professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
- You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to any adverse benefit determination. You will also be allowed to review the claim file and present evidence and testimony as part of the internal claims process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by ESI.

ELIGIBILITY, ENROLLMENT, CHANGE IN STATUS, SPECIAL ENROLLMENT, WHEN COVERAGE BEGINS AND WHEN COVERAGE ENDS

Please refer to the Eligibility & Enrollment Booklet for information regarding the following:

- Eligibility;
- Enrollment;
- Change in status;
- Special enrollment;
- Claims procedures for eligibility, enrollment, contributions and plan administrative determinations;
- Cost of coverage;
- When coverage begins;
- When coverage ends; and
- General provisions.

TERMINATION OF COVERAGE

For information on when coverage ends, refer to the “When Coverage Ends” section of the Eligibility & Enrollment Booklet.

Continuation of Group Coverage

For information regarding continuation of group coverage, please refer to COBRA Continuation Coverage provisions in the “When Coverage Ends” section of the Eligibility & Enrollment Booklet.

COORDINATION OF BENEFITS

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under This Plan are not reduced if the Order of Benefits Rules require this Plan to pay first. Your benefits under This Plan may be reduced if another plan pays first.

This section does not apply for your Prescription Drug Plan because there is no coordination of benefits for prescription drug coverage.

Definitions

These definitions apply only to this section.

1. The term “plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

    a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;

    b. coverage under a government plan or required or provided by law;

    c. individual coverage; and

    d. the medical payment (“medpay”) or personal injury protection benefit available to you under an automobile insurance policy.

    Therefore, “plan” does not include:

    a. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time);

    b. any benefits that, by law, are excess to any private or other nongovernmental program; or

    c. hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

    Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and the section applies only to one (1) part, each of the parts is a separate plan.

2. The term “This Plan” means the part of the Plan document that provides health care benefits.

3. “Primary Plan/Secondary Plan” is determined by the Order of Benefits Rules.

    When This Plan is a Primary Plan, its benefits are determined before any other plan and without considering the other plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits.

    When you are covered under more than two (2) plans, This Plan may be a Primary Plan to some plans, and may be a Secondary Plan to other plans.

    Notes:

    a. If you are covered under This Plan and Medicare: This Plan will comply with Medicare Secondary Payer (MSP) provisions of federal law, rather than the Order of Benefits Rules in this section, to determine which Plan is a primary Plan and which is a Secondary Plan. Medicare will be primary and This Plan will be secondary only to the extent permitted by MSP rules. When Medicare is the Primary Plan, This Plan will coordinate benefits up to Medicare's Allowed Amount.

    b. If you are covered under this Plan and TRICARE: This Plan will comply with the TRICARE provisions of federal law, rather than the Order of Benefit’s Rules in this section, to determine which Plan is a Primary

Plan and which is a Secondary Plan. TRICARE will be primary and this Plan will be secondary only to the extent permitted by TRICARE rules. When TRICARE is the Primary Plan, This Plan will coordinate benefits up to TRICARE'S Allowed Amount.

4. "Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or This Plan. "Allowable Expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number three (3) above).

   The difference between the cost of a private and a semiprivate hospital room is not considered an allowable expense unless admission to a private hospital room is medically necessary under generally accepted medical practice or as defined under This Plan.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

5. "Claim determination period" means a calendar year. However, it does not include any part of the year the person is not covered under This Plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

1. General: When a claim is filed under This Plan and another plan, This Plan is a Secondary Plan and determines benefits after the other plan, unless:

   a. the other plan has rules coordinating its benefits with This Plan's benefits; and

   b. the other plan's rules and This Plan's rules, in part 2. below, require This Plan to determine benefits before the other plan.

2. Rules: This Plan determines benefits using the first of the following rules that applies:

   a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.

   b. Nondependent/dependent: The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.

   c. Dependent child of parents not separated or divorced: When This Plan and another plan cover the same child as a dependent of different persons, called "parents":

      1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

      2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

      However, if the other plan does not have this rule for children of married parents, and instead the other plan has a rule based on the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

   d. Dependent child of parents divorced or separated or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Plan determines benefits in this order:

      1) first, the plan of the parent with physical custody of the child;

      2) then, the plan that covers the spouse of the parent with physical custody of the child;

3) finally, the plan that covers the parent not having physical custody of the child; or

4) in the case of joint physical custody, 2c. above applies.

However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

e. Active/inactive employee: The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.

f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

Effect on Benefits of This Plan

1. When this section applies: When the Order of Benefits Rules above require This Plan to be a Secondary Plan, this part applies. Benefits of This Plan may be reduced.

2. Reduction in This Plan's benefits

   The medical benefits that would be payable under This Plan, without applying coordination of benefits, are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under This Plan. This applies whether or not a claim is made under a plan.

   When a plan provides medical benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable. When medical benefits of This Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If this happens, This Plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If This Plan pays more than it should have paid under these coordination of benefit rules, This Plan may recover the excess from any of the following:

1. the persons This Plan paid or for whom This Plan has paid;

2. insurance companies; and

3. other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

REIMBURSEMENT AND SUBROGATION

For information regarding reimbursement and subrogation, please refer to the Subrogation and Reimbursement provisions in the “Plan Administration” section of the Eligibility & Enrollment Booklet.

Plan Administration

For information regarding Plan Administration, please refer to the “Plan Administration” section of the Eligibility & Enrollment Booklet.

Employee Retirement Income Security Act (ERISA) Statement of Rights

For information regarding Employee Retirement Income Security Act (ERISA) Statement of Rights, please refer to the “ERISA Rights” section of the Eligibility & Enrollment Booklet.

NONDISCRIMINATION – ACA SECTION 1557

Allina Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity or sex. Allina Health does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity or sex.

Allina Health:

- provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - qualified sign language interpreters, and
  - 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, and
  - information written in other languages.

If you need these services, contact the HR Service Center.

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

Allina Health Grievance Coordinator
P.O. Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-0900
Fax: 612-262-4370
GrievanceCoordinator@allina.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Allina Grievance Coordinator can 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-506-4595.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-506-4595.

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj key pab dawb rau koj. Hu rau 1-877-506-4595.

Somali: LA SOCO: Haddii aad ku hadashid af Sswoomaali, adeegyo gargaar luqad, oo bilaash ah, ayaa laguu heli karaa. Wac 1-877-506-4595.

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 1-877-506-4595.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-506-4595.

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-506-4595

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-506-4595.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-506-4595)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-506-4595.

Pennsylvanian Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-877-506-4595.

Laotion: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-506-4595.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-506-4595.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-506-4595.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-506-4595 पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-506-4595.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-506-4595.

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-506-4595.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-506-4595.

Karen: ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလ၊ တလၢာ်ဘူဉ်လၢာ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-877-506-4595.

Mon Khmer: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-506-4595.

GLOSSARY OF COMMON TERMS

Refer to the Benefit Chart for specific benefit and payment information.

Admission

A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Allowed Amount

The amount upon which payment is based for a given covered service for a specific provider. The Allowed Amount may vary from one provider to another for the same service. All benefits are based on the Allowed Amount, except as specified in the Benefit Chart.

The Allowed Amount for Participating Providers

For Participating Providers, the Allowed Amount is the negotiated amount of payment that the Participating Provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at Participating Providers as a result of expected settlements or other factors. The negotiated amount of payment with Participating Providers for certain covered services may not be based on a specified charge for each service, and the Claims Administrator uses a reasonable allowance to establish a per service Allowed Amount for such covered services.

Through settlements or other special arrangements with Participating Providers the Claims Administrator may prospectively or subsequently pay a different amount to a Participating Provider. Such payments will not affect or cause any change in the amount you paid at the time your claim was processed.

If the payment to the provider is decreased, the amount of the decrease is credited to the Plan, and the percentage of the Allowed Amount paid by the Plan is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Plan pays that cost on your behalf, and the percentage of the Allowed Amount paid is higher than the stated percentage.

Qualifications Applicable to All Nonparticipating Providers

In determining the Allowed Amount for Nonparticipating Providers, the Claims Administrator makes no representations that this Allowed Amount is a usual, customary, or reasonable charge from a provider. The Allowed Amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the Allowed Amount is subject to all of the Claims Administrator's business rules as defined in the Claims Administrator Provider Policy and Procedure Manual. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The Allowed Amount for Nonparticipating Providers in Minnesota

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the Allowed Amount will be based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) 140% of the Medicare Allowed

Charge for the same or similar service; (2) a percentage of billed charges; or (3) pricing based upon a nationwide provider reimbursement database The payment option selected by the Claims Administrator may result in an Allowed Amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator.

The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota

For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the Allowed Amount will be based upon one of the following payment options to be determined at an amount based upon one of the following payment options, to be determined by the Claims Administrator at its discretion: (1) a Minnesota Nonparticipating Provider fee schedule posted at the Claims Administrator's website; (2) 140% of the published Medicare allowed charge for the same or similar service; (3) a percentage of billed charges; (4) pricing determined by the Host Blue plan; or (5) pricing using a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an Allowed Amount that is a lower amount than if calculated by another payment option.

Special Circumstances

When you receive care from certain nonparticipating professionals at a participating facility such as a hospital, outpatient facility, or emergency room, the reimbursement to the nonparticipating professional may include some of the costs that you would otherwise be required to pay (e.g., the difference between the Allowed Amount and the provider's billed charge). This reimbursement applies when nonparticipating professionals are hospital-based and needed to provide immediate medical or surgical care and you do not have the opportunity to select the provider of care. The extent of reimbursement in these circumstances may also be subject to federal law.

If you have questions about the benefits available for services to be provided by a Nonparticipating Provider, you will need to speak with your provider and you may call the Claims Administrator Customer Service at the telephone number on the back of your member ID card for more information.

Artificial Insemination (AI)

The introduction of semen from a donor (which may have been preserved as a specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.

Assisted Reproductive Technologies (ART)

Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine insemination (IUI), or artificial insemination (AI)), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.

Attending health care professional

A health care professional with primary responsibility for the care provided to a sick or injured person.

Average semiprivate room rate

The average rate charged for semiprivate rooms. If the provider has no semiprivate rooms, the Claims Administrator uses the average semiprivate room rate for payment of the claim.

BlueCard Program

A national Blue Cross and Blue Shield program in which employees and dependents can receive health plan benefits while traveling or living outside the state of Minnesota. Employees and dependents must show their membership ID to secure benefits.

Calendar year

The period starting on January 1st of each year and ending at midnight December 31st of that year.

Claim

A written submission from your provider (or you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is not covered, the claim will be denied, meaning no payment is allowed.

Providers are required to use certain codes to explain the care they give you. The provider's medical records must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to contact your provider.

Claims Administrator

Blue Cross and Blue Shield of Minnesota (Blue Cross)

Coinsurance

The percentage of the Allowed Amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from Participating Providers, coinsurance is calculated based on the lesser of the Allowed Amount or the Participating Provider's billed charge. Because payment amounts are negotiated with Participating Providers to achieve overall lower costs, the Allowed Amount for Participating Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the Allowed Amount for Participating Providers, the percentage of the Allowed Amount paid by the Claims Administrator will be greater than the stated percentage.

For covered services from Out-of-Network Providers, coinsurance is calculated based on the Allowed Amount. In addition, you are responsible for any excess charge over the Allowed Amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Coinsurance Example:

	You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim: For instance, when the Claims Administrator pays 80% of the Allowed Amount for a covered service, you are responsible for the coinsurance, which is 20% of the Allowed Amount. In addition, you would be responsible for any excess charge over the Claims Administrator's Allowed Amount when an Out-of-Network Provider is used. For example, if an Out-of-Network Provider ordinarily charges $100 for a service, but the Claims Administrator's Allowed Amount is $95, the Claims Administrator will pay 80% of the Allowed Amount ($76). You must pay the 20% coinsurance on the Claims Administrator's Allowed Amount ($19), plus the difference between the billed charge and the Allowed Amount ($5), for a total responsibility of $24. Remember, if Participating Providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Claims Administrator's Allowed Amount. If Out-of-Network Providers are used, your out-of-pocket costs will be higher as shown in the example above.
Copay	The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.
Covered services	A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.
Custodial care	Services to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.
Cycle	One (1) partial or complete fertilization attempt extending through the implantation phase only.
Day treatment	Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.
Deductible	The amount you must pay toward the Allowed Amount for certain covered services each year before the Claims Administrator begins to pay benefits. The deductibles for each person and family are shown on the Benefit Chart. Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider’s charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

Dependent

Your spouse, child or dependent child as specified in the "Eligibility" section of the Eligibility & Enrollment Booklet.

Durable medical equipment

Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

E-Visit

An online evaluation and management service provided by a physician using the internet or similar secure communications network to communicate with an established patient.

Emergency hold

A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.

Extended hours skilled nursing care

Also referred to as private-duty nursing care, is complex nursing care services provided in a member's home for greater than four (4) hours in a 24-hour period.

Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Facility

A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, home health agency, or freestanding birthing center when services are billed on a facility claim.

Family therapy

Behavioral health therapy intended to treat an individual within the context of family relationships. The focus of the treatment is to identify problems or conflicts and to set specific goals for resolving them.

Foot orthoses

Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.

Freestanding ambulatory surgical center	A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.
Group home	A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.
Group therapy	Behavioral health therapy conducted with multiple patients.
Halfway house	Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.
Health care professional	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dieticians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
Home health agency	A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.
Hospice care	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.
Hospital	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
Host Blue	A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that require such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.
Illness	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
In-Network Provider	A provider that has entered into a specific network contract with the Claims Administrator or with the local Blue Cross and/or Blue Shield Plan. Refer to the Benefit Chart and Coverage Information sections for network details.

Intensive Outpatient Programs (IOP)

A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Intermediate maximum

The point where the Plan starts to pay 100% for certain covered services for the rest of the applicable plan or calendar year. Your Allowed Amounts must total the intermediate maximum.

Intermittent skilled nursing care

A visit by an employee or employees of an approved home health care agency of up to a total of four (4) hours in a 24 hour period .

Intrauterine Insemination (IUI)

A specific method of artificial insemination in which semen is introduced directly into the uterus.

Investigative

A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

1. the drug or device cannot be lawfully marketed without 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;
2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients);
3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

Reliable evidence shall also mean consensus opinions and recommendations reported in the relevant medical and scientific literature, peer-reviewed journals, reports of clinical trial committees, or technology assessment bodies, and professional expert consensus opinions of local and national health care providers.

Lifetime maximum

The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent's lifetime under all health plans sponsored by the Plan Administrator. The lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copays, penalties, and other amounts. Refer to the Benefit Chart for specific dollar maximums on certain services.

Marital/couples counseling

Behavioral health care services for the primary purpose of working through relationship issues.

Marital/couples training

Services for the primary purpose of relationship enhancements including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.

Medical emergency

Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.

Medically necessary

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare

A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.

Medicare allowed charge

The charge that Medicare would authorize as the cost of a service or supply from a provider that participates in Medicare. The Medicare allowed charge is adjusted by location in the United States according to Geographic Practice Cost Indices (GPCIs) calculated by Medicare. The Medicare allowed charge for covered inpatient care is based upon the Acute Hospital Inpatient Prospective Payment System (PPS). The Medicare allowed charge does not include additional amounts, such as Disproportionate Share Hospital, Direct Graduate Medical Education, outlier amounts or other charges that are not included in the Prospective Payment System amount. Payment for physician services is based solely upon the Medicare Physician Fee Schedule.

The determination of the Allowed Amount is subject to all Medicare payment rules. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or other reductions consistent with Medicare payment procedures resulting from the procedures performed and billed on the claim.

The Medicare allowable charge that is current as of the time the services are provided will be the amount that is used in determining the Allowed Amount.

Mental illness	A mental disorder as defined in the International Classification of Diseases. It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.
Neuro-psychological examinations	Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.
Nonparticipating Provider	A provider that has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
Opioid treatment	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
Out-of-Network Provider	A Participating Provider that is not In-Network; and Nonparticipating Providers.
Out-of-pocket maximum	The most each person must pay each applicable plan or calendar year toward the Allowed Amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the Allowed Amount for covered services for that person for the rest of the applicable plan or calendar year. The Benefit Chart lists the out-of-pocket maximum amounts.
Outpatient behavioral health treatment facility	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Outpatient care	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
Palliative care	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.
Partial programs	An intensive structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.
Participating Provider	A provider who has entered into a specific network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
Physician	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.

Place of service	Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers. Providers use different types of claim forms to bill for services based on the "place of service." Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility.
Plan	The plan of benefits established by the Plan Administrator.
Plan year	A 12-month period which begins on the effective date of the Plan, as stated in the Introduction section, and each succeeding 12-month period thereafter.
Provider	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories, ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.
Reproduction treatment	Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.
Residential behavioral health treatment facility	A facility licensed under state law in the state in which it is located that provides treatment by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.) for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
Respite care	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
Retail health clinic	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
Services	Health care service, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.

Skilled care

Services that are medically necessary and provided by a licensed nurse or other licensed health care professional (up to four (4) hours in a 24 hour period). A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.

Skilled nursing facility

A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills training

Training of basic living and social skills that restore a patient's skills essential for managing his or her illness, treatment and the requirements of everyday independent living.

Substance abuse and/or addictions

Alcohol, drug dependence or other addictions as defined in the most current edition of the International Classification of Diseases.

Supervised employees

Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50 percent of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supply

Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.

Supplies do not include such things as:

1. alcohol swabs;
2. cotton balls;
3. incontinence liners/pads;
4. Q-tips;
5. adhesives; or
6. informational materials.

Surrogate pregnancy

An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.

Terminally ill patient

An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.

Therapeutic camps

A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.

Therapeutic day care (pre-school)	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.
Therapeutic support of foster care	Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child's improved functioning.
Treatment	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, and monitoring and tracking medication.