BlueCross BlueShield Minnesota

University of Minnesota Graduate Assistants Dependent Plan 2

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmnonline.com or call toll-free 1-866-873-5943. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.
You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call toll-free 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$100 individual medical In-network $200 family medical In-network $100 individual medical Out-of-Network $200 family medical Out-of-Network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. In-network Office visit copays, Prescription drug coverage, are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$1,000 individual medical combined Network and Out-of-Network $2,000 family medical combined Network and Out-of-Network Pharmacy: $300 individual, $500 family combined Network and Out-of-Network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.bluecrossmn.com/umnga https://www.bluecrossmn.com/umnga or call toll-free 1-866-873-5943 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury	$25 office visit copay per visit; $10 Convenience Clinic copay deductible does not apply to services subject to a copay; 10% coinsurance for all other services	10% coinsurance Convenience Clinic 10% coinsurance	----------none----------
	Specialist visit	$25 office visit copay per visit; deductible does not apply to services subject to a copay; 10% coinsurance for all other services	10% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	10% coinsurance for adult preventive services No charge for well-childcare services	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.myprime.com	Preferred generic drugs	$10.00 copay/retail $20.00 copay/mail service $20.00 copay/90dayRx Retail Deductible does not apply	$10.00 copay/retail Deductible does not apply	Covers up to 34-day supply (retail prescription) 90-day supply (mail order or 90dayRx Retail prescription). No coverage for mail order and 90dayRx Retail services from out-of-network providers.
	Preferred brand drugs	$25.00 copay/retail $50.00 copay/mail service $50.00 copay/90dayRx Retail Deductible does not apply	$25.00 copay/retail Deductible does not apply	
	Non-preferred drugs	Non-preferred generic drugs: $50.00 copay/retail $100.00 copay/mail service $100.00 copay/90dayRx Retail Non-preferred brand drugs: $50.00 copay/retail $100.00 copay/mail service $100.00 copay/90dayRx Retail Deductible does not apply	Non-preferred generic drugs: $50.00 copay/retail Non-preferred brand drugs: $50.00 copay/retail Deductible does not apply	
	Specialty drugs	Formulary: $10 copay/prescription, Brand: $25 copay/90-day prescription, Non-formulary: $50 copay/prescription. 100% coverage after copay for all. Deductible does not apply.	Not covered	Covers up to 34-day supply (Specialty Pharmacy Network Supplier prescription) No coverage for services from out-of-network providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	----------none----------
	Physician/surgeon fees	10% coinsurance	10% coinsurance	----------none----------
If you need immediate	Emergency room care	10% coinsurance	10% coinsurance	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	$25 office visit copay per visit; deductible does not apply to services subject to a copay; 10% coinsurance for all other services	10% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	----------none----------
	Physician/surgeon fee	10% coinsurance	10% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 office visit copay per visit; deductible does not apply to services subject to a copay; $10 Doctor on Demand copayment per visit; 10% coinsurance for all other services	10% coinsurance	Services for marriage/couples counseling are not covered.
	Inpatient services	10% coinsurance	10% coinsurance	----------none----------
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $25 office visit copayment per visit	Prenatal care: No charge Postnatal care: 10% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Limit of 120 visits per benefit period when you use Network Providers. Limit of 60 visits per benefit period when you use out-of-Network Providers.
	Rehabilitation services	$25 office visit copay per visit for occupational therapy; deductible does not apply;	10% coinsurance for occupational therapy 10% coinsurance for physical	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		therapies apply 10% coinsurance after deductible $25 office visit copay per visit for physical therapy; deductible does not apply; therapies apply 10% coinsurance after deductible $25 office visit copay per visit for speech therapy; deductible does not apply therapies apply 10% coinsurance after deductible	therapy 10% coinsurance for speech therapy	
	Habilitation services	$25 office visit copay per visit for occupational therapy; deductible does not apply; therapies apply 10% coinsurance after deductible $25 office visit copay per visit for physical therapy; deductible does not apply; therapies apply 10% coinsurance after deductible $25 office visit copay per visit for speech therapy; deductible does not apply; therapies apply 10% coinsurance after deductible	10% coinsurance for occupational therapy 10% coinsurance for physical therapy 10% coinsurance for speech therapy	
	Skilled nursing care	10% coinsurance	10% coinsurance	Combined Network and out-of-network: 120 days per Plan Year.
	Durable medical equipment	10% coinsurance	10% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice service	10% coinsurance	10% coinsurance	----------none----------
If your child needs dental or	Children's eye exam	No charge	No coverage	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
eye care	Children's glasses	No charge	Not covered	One pair of eyeglasses or contacts per benefit period.
	Dental check-up	No charge	Not covered	Services provided exclusively through BHS Dental Clinic. Coverage provided by Delta Dental of Minnesota

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery (unless for removal of port wine stain, reconstructive surgery)
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture for treatment of chronic pain (defined as a duration of at least six months) or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
- Bariatric surgery
- Chiropractic care
- Hearing aids (limited to one external hearing aid for each ear every three years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your Claims Administrator by calling toll-free 1-866-873-5943 or if you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 888-393-2789.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

Language Access Services:

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

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

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

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

နမ့်ကတိၤကညီကျိာ်ဒီး, တ၀်ကဟ့ဉ်နၤကျိာ်တ၀်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်, ကိး 711 တက့၀်.

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

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

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

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

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,060

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$760

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400

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