BlueCross BlueShield Minnesota

University of Minnesota Graduate Assistants and Dependent Plan 1

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?	$200 individual medical Out-of-Network $600 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. Out of network Well-child care, prenatal care, Emergency room services, Emergency medical transportation, and Durable medical equipment services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$2,500 individual medical combined Network and Out-of-Network, None Family Pharmacy: $300 individual	The out-of-pocket limit is the most you could pay in a year for covered services.

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 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	$10 office visit copay per visit; $5 Convenience Clinic copay no charge for all other services	20% coinsurance	----------none----------
	Specialist visit	$10 office visit copay per visit; no charge for all other services	20% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	20% coinsurance for adult preventive services No charge for well-child care services 20% coinsurance for Preventive care,20% coinsurance for other 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	0% coinsurance; deductible does not apply	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.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 Deductibe does not apply	Non-preferred generic drugs: $50.00 copay/retail Non-preferred brand drugs: $50.00 copay/retail Deductibe 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)	No charge	0% coinsurance; deductible does not apply	----------none----------
	Physician/surgeon fees	No charge	20% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$40.00 copay/visit	$40.00 copay/visit; deductible does not apply	----------none----------
	Emergency medical transportation	20% coinsurance	20% coinsurance; deductible does not apply	----------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)	
	Urgent care	$10 office visit copay per visit; 0% coinsurance for all other services	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	0% coinsurance; deductible does not apply	----------none----------
	Physician/surgeon fee	No charge	20% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 office visit copay per visit; no charge for all other services	20% coinsurance	Services for marriage/couples counseling are not covered.
	Inpatient services	No charge	0% coinsurance; deductible does not apply	----------none----------
If you are pregnant	Office visits	No charge	0% coinsurance; deductible does not apply	Cost sharing does not apply for preventive services. Depending on the type of services, a deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	0% coinsurance; deductible does not apply	
	Childbirth/delivery facility services	No charge	0% coinsurance; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge	0% coinsurance; deductible does not apply	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	$10 office visit copay per visit for occupational therapy; No charge for therapies$10 office visit copay per visit for physical therapy; No charge for therapies$10 office visit copay per visit for speech therapy; No charge for therapies	20% coinsurance for occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	----------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)	
	Habilitation services	$10 office visit copay per visit for occupational therapy; No charge for therapies$10 office visit copay per visit for physical therapy; No charge for therapies $10 office visit copay per visit for speech therapy; No charge for therapies	20% coinsurance for occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	
	Skilled nursing care	No charge	0% coinsurance; deductible does not apply	Combined Network and out-of-network: 120 days per Plan Year.
	Durable medical equipment	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	Limited to one wig per year for Alopecia Areata
	Hospice service	No charge	20% coinsurance	----------none----------
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance; deductible does not apply	----------none----------
	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.

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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.

နမ့်ကတိၤကညီကျိာ်ဒိး. တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်. ကိး 711 တက့ၢ်.

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

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

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

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

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

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

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

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

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

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

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

Diné k'ehjí yánílt'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	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$120

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$0
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,160

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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	$0
Copayments	$200
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.