## Important Questions

### What is the overall deductible?
- **Answers**: $400 individual / $1,200 family medical combined in-network and out-of-network.
- **Why this Matters**: Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

### Are there services covered before you meet your deductible?
- **Answers**: Yes. Well child care, prenatal care and in-network preventive care services are covered before you meet your deductible.
- **Why this Matters**: 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

### Are there other deductibles for specific services?
- **Answers**: No
- **Why this Matters**: You don’t have to meet deductibles for specific services.

### What is the out-of-pocket limit for this plan?
- **Answers**: $2,000 individual / $4,000 family medical combined in-network and out-of-network. $750 individual / $1,000 family drug combined in-network and out-of-network.
- **Why this Matters**: 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?
- **Answers**: Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn’t cover.
- **Why this Matters**: Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
### Will you pay less if you use an **in-network provider**?

Yes. Your network is Aware. See [bluecrossmn.com/find-a-doctor/#/home](bluecrossmn.com/find-a-doctor/#/home) or call 1-866-873-5943 for a list of **in-network providers**.

This plan uses a **provider network**. If you 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 **in-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**.

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What you Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Well child: 0% <strong>coinsurance</strong> Adult: 0% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at bluecrossmn.com</strong></td>
<td>Preferred generic drugs</td>
<td>$15.00 <strong>copay, deductible</strong> does not apply/prescription (retail) $30.00 <strong>copay, deductible</strong> does not apply/prescription (mail service) $30.00 <strong>copay, deductible</strong> does not apply/prescription (90dayRx retail)</td>
<td><strong>$15.00 copay, deductible</strong> does not apply/prescription (retail) Covers up to a 31-day supply (retail prescription). 90-day supply (mail service prescription and 90dayRx retail prescription). No coverage for mail service and 90dayRx retail services from all <strong>out-of-network providers</strong>.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What you Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>In-Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$30.00 <strong>copay, deductible</strong> does not apply/prescription (retail) $60.00 <strong>copay, deductible</strong> does not apply/prescription (mail service) $60.00 <strong>copay, deductible</strong> does not apply/prescription (90dayRx retail)</td>
<td>$30.00 <strong>copay, deductible</strong> does not apply/prescription (retail)</td>
<td>Insulin listed on the preferred generic/preferred brand <strong>prescription drug</strong> list are covered at zero <strong>cost-sharing</strong>. The value of drug coupons you use will not count towards <strong>cost sharing</strong> or <strong>out-of-pocket limits</strong>. May require prior authorization.</td>
</tr>
<tr>
<td>Non-preferred generic drugs</td>
<td>$45.00 <strong>copay, deductible</strong> does not apply/prescription (retail) $90.00 <strong>copay, deductible</strong> does not apply/prescription (mail service) $90.00 <strong>copay, deductible</strong> does not apply/prescription (90dayRx retail)</td>
<td>$45.00 <strong>copay, deductible</strong> does not apply/prescription (retail)</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$45.00 <strong>copay, deductible</strong> does not apply/prescription (retail) $90.00 <strong>copay, deductible</strong> does not apply/prescription (mail service) $90.00 <strong>copay, deductible</strong> does not apply/prescription (90dayRx retail)</td>
<td>$45.00 <strong>copay, deductible</strong> does not apply/prescription (retail)</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Refer to applicable <strong>prescription drug cost sharing</strong></td>
<td>Not covered</td>
<td>Covers up to a 31-day supply (participating <strong>specialty drug</strong> network supplier prescription). May require prior authorization.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center) 20% <strong>coinsurance</strong> for outpatient hospital facility &amp; ambulatory surgery center</td>
<td>20% <strong>coinsurance</strong></td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees 20% <strong>coinsurance</strong> for outpatient hospital facility &amp; ambulatory surgery center</td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate care</td>
<td><strong>Emergency room care</strong> 20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td><strong>Out-of-network</strong> services apply to</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What you Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance use services</strong></td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>Services for marriage/couples counseling are not covered. May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services including residential adult mental health treatment</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Prenatal care: No charge</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>Limit of $500 per member per benefit period for occupational and physical therapy services when you use out-of-network providers. May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance for occupational therapy, physical therapy, and speech therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance for occupational therapy, physical therapy, and speech therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>No coverage for these services</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>No coverage for these services</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see the plan or policy document at bluecrossmn.com
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>(Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
<td>• Hearing aids (Adult)</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Dental care (Adult) (and children)</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td></td>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td></td>
<td>• Routine foot care</td>
</tr>
<tr>
<td></td>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td>• Routine eye care (Adult)</td>
</tr>
</tbody>
</table>

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 Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or, Department of Health and Human Services, Center for Consumer Information, and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.mnsure.org or call 1-855-366-7873.

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 on how 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: Blue Cross at 1-866-873-5943; Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, Service Cooperative, or church plan, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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

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

Language Access Services:


Navajo (Dine): Dinek'ehgo shika a'tohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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

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review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
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.

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

- **The plan’s overall deductible** $400
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **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** $12,700

**In this example, Peg would pay:**
- **Deductibles** $400
- **Copayments** $10
- **Coinsurance** $1,600

**What isn’t covered**
- Limits or exclusions $60
- **The total Peg would pay is** $2,070

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

- **The plan’s overall deductible** $400
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **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** $5,600

**In this example, Joe would pay:**
- **Deductibles** $400
- **Copayments** $100
- **Coinsurance** $300

**What isn’t covered**
- Limits or exclusions $20
- **The total Joe would pay is** $820

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

- **The plan’s overall deductible** $400
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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

**Total Example Cost** $2,800

**In this example, Mia would pay:**
- **Deductibles** $400
- **Copayments** $0
- **Coinsurance** $400

**What isn’t covered**
- Limits or exclusions $0
- **The total Mia would pay is** $800

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

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For more information about limitations and exceptions, see the plan or policy document at bluecrossmn.com
Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross 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 us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross 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 and Blue Plus - M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201


For more information about limitations and exceptions, see the plan or policy document at bluecrossmn.com
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.


Haddii aad ku hadashe 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.

If you speak another language, you can receive free language assistance services. Call 1-855-903-2583. For TTY, call 711.

For more information about limitations and exceptions, see the plan or policy document at bluecrossmn.com