BlueCross BlueShield Minnesota

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Hubbard County

Coverage Period: Beginning on or after 01-01-2016

Summary of Benefits and Coverage: What this Plan covers & What it Costs**Coverage for:** Single and family coverage | **Plan Type:** HSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bluecrossmn.com/mnservcoop** or by calling (651) 662-5517 or toll-free 1-888-878-0136.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** medical and drug per person all providers **$10,000** medical and drug per family all providers Does not apply to preventive care services from all providers Does not apply to prenatal care services from all providers Does not apply to well child care services from all providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** must be met before applicable coinsurance is applied. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. This plan has an embedded **deductible**. The plan begins paying benefits that require cost sharing for the first family member who meets the per-person **deductible**. The family **deductible** must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.
Are there other deductibles for specific services?	No, there are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

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Important Questions	Answers	Why this Matters:
Is there an out-of-pocket limit on my expenses?	Yes. **$5,000** medical and drug per person all providers **$10,000** medical and drug per family all providers	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, deductible carryover, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.bluecrossmn.com/mnservcoop or call (651) 662-5517 or toll-free 1-888-878-0136.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4 or 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000.00, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000.00, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	_____none_____
	Specialist visit	0% coinsurance	0% coinsurance	_____none_____
	Other practitioner office visit	0% coinsurance for Chiropractors	0% coinsurance for Chiropractors	_____none_____
	Preventive care/screening/immunization	0% coinsurance	0% coinsurance	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	_____none_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossmn.com/mnservcoop.	Generic drugs	0% coinsurance for retail drugs 0% coinsurance for mail service pharmacy drugs	0% coinsurance for retail drugs Not covered for mail service pharmacy drugs	No coverage for mail service pharmacy drugs from Out-of-Network providers. No coverage for non-preferred generic retail and mail order drugs.
	Preferred brand drugs	0% coinsurance for retail drugs 0% coinsurance for mail service pharmacy drugs	0% coinsurance for retail drugs Not covered for mail service pharmacy drugs	No coverage for mail service pharmacy drugs from Out-of-Network providers.
	Non-preferred brand drugs	Not covered for retail drugs Not covered for mail service pharmacy drugs	Not covered for retail drugs Not covered for mail service pharmacy drugs	No coverage for retail drugs for services from In-Network and Out-of-Network providers. No coverage for mail service pharmacy drugs for services from In-Network and Out-of-Network providers.

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	No coverage for Out-of-Network providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	_____none_____
	Physician/surgeon fees	0% coinsurance	0% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	_____none_____
	Emergency medical transportation	0% coinsurance	0% coinsurance	_____none_____
	Urgent care	0% coinsurance	0% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	_____none_____
	Physician/surgeon fee	0% coinsurance	0% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	0% coinsurance	Services for marriage/couples counseling is not covered.
	Mental/Behavioral health inpatient services	0% coinsurance	0% coinsurance	_____none_____
	Substance use disorder outpatient services	0% coinsurance	0% coinsurance	_____none_____
	Substance use disorder inpatient services	0% coinsurance	0% coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	0% coinsurance	0% coinsurance	_____none_____
	Delivery and all inpatient services	0% coinsurance	0% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	_____none_____
	Rehabilitation services	0% coinsurance for occupational therapy 0% coinsurance for physical therapy	0% coinsurance for occupational therapy 0% coinsurance for physical therapy	_____none_____

Common Medical Event	Services You May Need	Your cost if you use an In Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
		0% coinsurance for speech therapy	0% coinsurance for speech therapy	
	Habilitation services	0% coinsurance for occupational therapy 0% coinsurance for physical therapy 0% coinsurance for speech therapy	0% coinsurance for occupational therapy 0% coinsurance for physical therapy 0% coinsurance for speech therapy	_____none_____
	Skilled Nursing Facility	0% coinsurance	0% coinsurance	Up to a maximum of 120 days per calendar year for all inpatient facility services combined.
	Durable medical equipment	0% coinsurance	0% coinsurance	_____none_____
	Hospice service	0% coinsurance	Not covered	No coverage for services from Out-of-Network providers.
If your child needs dental or eye care	Eye exam	0% coinsurance	0% coinsurance	_____none_____
	Glasses/Eyewear	Not covered	Not covered	Services are not covered.
	Dental check-up	Not covered	Not covered	Services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**	**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**
• Cosmetic surgery (except as specified in Plan benefits) • Dental Care • Long-Term Care • Non-preferred brand drugs • Non-preferred generic drugs • Routine foot care • Weight loss programs	• Acupuncture (subject to coverage limitations) • Bariatric surgery • Chiropractic Care • Hearing aids • Infertility treatment • Most non-emergency care when traveling outside the U.S. • Private-duty nursing

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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information, on your rights to continue coverage, contact the plan at (651) 662-5517 or toll-free 1-888-878-0136. You may also contact your state insurance department, the U.S. Department of labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your Claims Administrator by calling (651) 662-5517 or toll-free 1-888-878-0136. 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 Assistance Team at 888-393-2789.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Statement?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Chinese (中文): 如果需要中文的帮助，请拨打这个号码	1-888-878-0136
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-888-878-0136
Spanish (Español): Para obtener asistencia en Español, llame al	1-888-878-0136

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-878-0136

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

The "Patient pays" amounts assume the patient is not using funds from a Flexible Spending Account (FSA), a Health Savings Account (HSA), or an integrated Health Reimbursement Arrangement (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $2,900**
- **Patient pays $4,640**

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$4,490
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$4,640**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $320**
- **Patient pays $5,080**

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not excluded.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments, deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.