BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

# BlueAccess Platinum No Deductible Plan 242

**Coverage Period: Beginning on or after 01-01-2015**

**Summary of Benefits and Coverage:** What this Plan covers & What it Costs **Coverage for:** Single and Family | **Plan Type:** PPO

**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** or by calling (651) 662-5030 or toll-free 1-800-531-6685.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0**/per person In-Network for medical services<br>**$0**/per family In-Network for medical services<br>**$10,000**/per person Out-of-Network for medical services<br>**$20,000**/per family Out-of-Network for medical services | 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**.<br>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.<br>The **deductible** does not apply to services subject to a copay. |
| **Are there other deductibles for specific services?** | No. | 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. |
| **Is there an out-of-pocket limit on my expenses?** | **$2,500**/per person In-Network for medical services and prescription drugs<br>**$5,000**/per family In-Network for medical services and prescription drugs<br>**None**/Out-of-Network | 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, Out-of-Network services 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. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. For a list of preferred providers, see www.bluecrossmn.com or call (651) 662-5030 or toll-free 1-800-531-6685. | 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**.** 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, 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, 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 | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Specialist visit | $40 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Other practitioner office visit | $20 copay for the office visit; 10% coinsurance for all other eligible chiropractic services | 50% coinsurance for chiropractic services | Deductible does not apply to services subject to a copay. |
| | Preventive care/screening/immunization | 0% coinsurance | 50% coinsurance | Well-child services are covered at 0% coinsurance Out-of-Network and deductible does not apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 50% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance | ——————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 |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>**A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Service Pharmacy dispenses prescription drugs through the U.S. Mail.**<br>More information about **prescription drug coverage** is available at www.bluecrossmn.com. | Generic drugs | $5 copay/retail for preferred generic drugs<br>$15 copay/mail for preferred generic drugs | $5 copay/retail for preferred generic drugs<br>Not covered mail order drugs | 31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs.<br>Deductible does not apply. |
| | Preferred brand drugs | $15 copay/retail<br>$45 copay/mail | $15 copay/retail<br>Not covered mail order drugs | 31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs.<br>Deductible does not apply. |
| | Non-preferred drugs | $50 copay/retail<br>$150 copay/mail | $50 copay/retail<br>Not covered mail order drugs | 31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs.<br>Deductible does not apply. |
| | Specialty drugs | 10% coinsurance to a maximum of $100 per prescription | Not covered | No coverage for services from Out-of-Network providers.<br>Deductible does not apply. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | ——none—— |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | ——none—— |
| **If you need immediate medical attention** | Emergency room services | $150 copay | $150 copay | Deductible does not apply to services subject to a copay. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | ——none—— |
| | Urgent care | $20 General Physician copay or $40 Specialty Physician copay for the office visit whichever is applicable; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 copay per admission | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Physician/surgeon fee | 10% coinsurance | 50% coinsurance | ——none—— |

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Mental/Behavioral health inpatient services | $200 copay per admission | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Substance use disorder outpatient services | $20 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Substance use disorder inpatient services | $200 copay per admission | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| **If you are pregnant** | Prenatal and postnatal care | 0% coinsurance for prenatal care<br>10% coinsurance for postnatal care | 0% coinsurance for prenatal care<br>50% coinsurance for postnatal care | Deductible does not apply to prenatal care services. |
| | Delivery and all inpatient services | 10% coinsurance | 50% coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | Not covered | Coverage is limited to 120 visits per person per calendar year.<br>No coverage for services from Out-of-Network providers. |
| | Rehabilitation services | $20 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Habilitation services | $20 copay for the office visit; 10% coinsurance for all other eligible services | 50% coinsurance | Deductible does not apply to services subject to a copay. |
| | Skilled nursing care | $200 copay per admission | 50% coinsurance | Coverage is limited to 120 days per person per period of confinement.<br>Deductible does not apply to services subject to a copay. |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance | ——————none—————— |

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| | Hospice service | 10% coinsurance | Not covered | Coverage is limited to 30 days per person per calendar year.<br>No coverage for services from Out-of-Network providers. |
| **If your child needs dental or eye care** | Eye exam | 0% coinsurance | 50% coinsurance | Deductible does not apply to In-network eye exam services. |
| | Glasses/Eyewear | 10% coinsurance | 50% coinsurance | Maximum of: one (1) frame and one (1) pair of lenses; or, one (1) pair of contact lenses; or, one (1) year supply of disposable contact lenses per person per calendar year. |
| | Dental check-up | Not covered | Not covered | No coverage for these services. |

## 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.)** |
|---|---|
| • Bariatric surgery<br>• Cosmetic surgery (except as specified in Plan benefits)<br>• Dental Care<br>• Infertility treatment<br>• Long Term Care<br>• Routine foot care<br>• Weight loss programs | • Acupuncture (subject to coverage limitations)<br>• Chiropractic Care<br>• Hearing aids (as required by state law)<br>• Non-emergency care when traveling outside the U.S.<br>• Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing (as required by state law)<br>• Routine eye care (Adult) |

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information, on your rights to continue coverage, contact the insurer at (651) 662-5030 or toll-free 1-800-531-6685. You may also contact your state insurance department at:

Minnesota Department of Commerce
Attention: Consumer Concerns/Market Assurance Division
85 7th Place East Suite 500
St. Paul, MN 55101-2198

## 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 Standard?

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.**

## 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: Minnesota Commissioner of Commerce by calling (651) 539-1600 or toll-free 1-800-657-3602. 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.

## Language Access Services:

| | |
|---|---|
| Chinese (中文): 如果需要中文的帮助，请拨打这个号码 | 1-888-878-0138 |
| Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' | 1-888-878-0138 |
| Spanish (Español): Para obtener asistencia en Español, llame al | 1-888-878-0138 |
| Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa | 1-888-878-0138 |

*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 $7,180**
- **Patient pays $360**

**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 | $0 |
| Copays | $210 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$360** |

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,650**
- **Patient pays $750**

**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 | $0 |
| Copays | $540 |
| Coinsurance | $130 |
| Limits or exclusions | $80 |
| **Total** | **$750** |

# 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.