

## BlueAccess Gold \$1000 Plan 725

Coverage Period: Beginning on or after 01-01-2017

Coverage for: Single and family | Plan Type: PPO

### Summary of Benefits and Coverage: What this Plan covers & What it Costs

 **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.bluecrossmnonline.com](http://www.bluecrossmnonline.com) or by calling toll-free 1-888-279-4210.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<p><b>\$1,000</b>/per person In-Network for medical services</p> <p><b>\$2,000</b>/per family In-Network for medical services</p> <p><b>\$10,000</b>/per person Out-of-Network for medical services</p> <p><b>\$20,000</b>/per family Out-of-Network for medical services</p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. The <b>deductible</b> must be met before applicable coinsurance is applied. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1<sup>st</sup>). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p> <p>This plan has an embedded <b>deductible</b>. The plan begins paying benefits that require cost sharing for the first family member who meets the per-person <b>deductible</b>. The family <b>deductible</b> must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.</p> <p>The <b>deductible</b> does not apply to services subject to a copay.</p>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	<p><b>\$3,300</b>/per person In-Network for medical services and prescription drugs</p> <p><b>\$6,600</b>/per family In-Network for medical services and prescription drugs</p> <p><b>\$30,000</b>/per person Out-of-Network for medical services and prescription drugs</p> <p><b>\$60,000</b>/per family Out-of-Network for medical services and prescription drugs</p>	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or by calling toll-free 1-888-279-4210 to request a copy.

Important Questions	Answers	Why this Matters:
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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see <a href="http://www.bluecrossmnonline.com">www.bluecrossmnonline.com</a> or call toll-free 1-888-279-4210.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No.	You can see the <b>specialist</b> 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 <b>excluded services</b> .

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- **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 <b>provider's office or clinic</b>	Primary care visit to treat an injury or illness	You pay \$30 copay for the office visit charge; then 20% coinsurance for all other eligible services	50% coinsurance	<b>Deductible</b> does not apply to services subject to a copay.
	Specialist visit	You pay \$50 copay for the office visit charge; then 20% coinsurance for all other eligible services	50% coinsurance	<b>Deductible</b> does not apply to services subject to a copay.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Other practitioner office visit	You pay \$30 copay for the office visit charge; then 20% coinsurance for all other eligible chiropractic services	50% coinsurance for chiropractic services	<b>Deductible</b> does not apply to services subject to a copay.
	Preventive care/screening/immunization	No charge	No charge for well-child services 50% coinsurance for adult preventive services	—————none—————
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	—————none—————
<b>If you need drugs to treat your illness or condition</b> <b>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.</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bluecrossmn.com/GenRx-IND-SG">www.bluecrossmn.com/GenRx-IND-SG</a> .	Preferred generic drugs	\$10 copay/retail \$30 copay/mail	\$20 copay/retail Not covered mail order drugs	31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs. <b>Deductible</b> does not apply to services subject to a copay.
	Preferred brand drugs	\$50 copay/retail \$150 copay/mail	\$100 copay/retail Not covered mail order drugs	31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs. <b>Deductible</b> does not apply to services subject to a copay.
	Non-preferred drugs	\$150 copay/retail \$450 copay/mail	\$300 copay/retail Not covered mail order drugs	31-day supply for retail prescription drugs. 93-day supply for mail order prescription drugs. <b>Deductible</b> does not apply to services subject to a copay.
	Specialty drugs	20% coinsurance to a maximum of \$300 per prescription/retail Not Covered mail order drugs	Not covered	No coverage for services from Out-of-Network providers.

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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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for outpatient hospital facility services 0% coinsurance for ambulatory surgery center services	50% coinsurance	none
	Physician/surgeon fees	20% coinsurance	50% coinsurance	none
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	none
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	You pay \$30 General Physician copay or \$50 Specialty Physician copay for the office visit charge whichever is applicable; then 20% coinsurance for all other eligible services	50% coinsurance	<b>Deductible</b> does not apply to services subject to a copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	none
	Physician/surgeon fee	20% coinsurance	50% coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	You pay \$30 copay for the office visit charge; then 20% coinsurance for all other eligible services	50% coinsurance	<b>Deductible</b> does not apply to services subject to a copay.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	none
	Substance use disorder outpatient services	You pay \$30 copay for the office visit charge; then 20% coinsurance for all other eligible services	50% coinsurance	<b>Deductible</b> does not apply to services subject to a copay.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	none

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care 20% coinsurance for postnatal care	No charge for prenatal care 50% coinsurance for postnatal care	none
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	none
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Coverage is limited to 120 visits per person per calendar year. No coverage for services from Out-of-Network providers.
	Rehabilitation services	20% coinsurance	50% coinsurance	none
	Habilitation services	20% coinsurance	50% coinsurance	none
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 120 days per person per period of confinement.
	Durable medical equipment	20% coinsurance	50% coinsurance	none
	Hospice service	20% coinsurance	Not Covered	No coverage for services from Out-of-Network providers.
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	none
	Glasses/Eyewear	20% coinsurance	Not Covered	Maximum of: one (1) standard 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. No coverage for services from Out-of-Network providers.
	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 <u>excluded services</u> .)	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.)
<ul style="list-style-type: none"> <li>Acupuncture (except as specified in Plan benefits)</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Hearing aids (as required by state law)</li> </ul>

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<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	<b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
<ul style="list-style-type: none"> <li>• Cosmetic surgery (except as specified in Plan benefits)</li> <li>• Dental Care (except as specified in Plan benefits)</li> <li>• Infertility treatment</li> <li>• Long-Term Care</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing (as required by state law)</li> <li>• Routine eye care (Adult)</li> </ul>

### **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 toll-free 1-888-279-4210. You may also contact your state insurance department at:

Minnesota Department of Commerce  
 Attention: Consumer Concerns/Market Assurance Division  
 85 7<sup>th</sup> 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.

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## **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 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 customer service using the telephone number on the back of your member identification card. TTY: 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 mailing it to:

Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus  
PO Box 64560, M495,  
Eagan, MN 55122-1154

Grievance forms are available by contacting us at the telephone numbers listed above. If you need help filing a grievance, assistance is available by contacting us at the telephone 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>; or by telephone at:

1-800-368-1019 or 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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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## Language Access Services:

~~This notice has important information about your application or health plan coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your coverage or to receive help with costs. If you, or someone you're helping, has questions about this notice or health plan coverage, you can receive help and information in your language at no cost. To talk to an interpreter, call 1-800-382-2000 (toll-free).~~

**Este aviso tiene información importante sobre su solicitud o cobertura del plan de salud. Busque fechas clave en este aviso. Es posible que deba tomar medidas antes de ciertos plazos para mantener su cobertura o recibir ayuda con los costos. Si usted, o alguien a quien esté ayudando, tiene preguntas sobre este aviso o sobre la cobertura del plan de salud, puede recibir información y ayuda en su idioma sin costo. Para comunicarse con un intérprete, llame al número gratuito 1-855-903-2583.**

**Tsab ntawv ceeb toom no muaj cov lus tseem ceeb hais txog koj daim ntawv thov los yog qhov kev pab them rau koj daim phiaj npaj kho mob. Saib cov hnuv tseem ceeb nyob hauv daim ntawv ceeb toom no. Tej zaum koj yuav tau ua qee yam kom tiav ua ntej qee cov hnuv uas teev rau hauv no kom thiaj tsis poob qhov kev pab them los yog kom tau txais kev pab them cov nqi kho mob. Yog hais tias koj, los yog lwv tus uas koj pab, muaj lus nug txog tsab ntawv ceeb toom no los yog qhov kev pab them rau daim phiaj npaj kho mob, koj muaj cai tau txais kev pab thiab ntaub ntawv ua koj hom lus yam tsis tau them nyiaj dab tsi. Yog xav tham nrog ib tus neeg pab txhais lus, hu rau tus xov tooj 1-800-793-6931 (hu dawb).**

**Ogeysiiskani wuxuu wataa macluumaad muhiim ah oo ku saabsan caynsanaanta qorshahaaga caafimaad. U fiirso taariikhaha ku yaal ogeysiiskan. Waxa laga yaabaa inaad u baahto ficil ka qaad taariikhaha kama dambayska ah si aad u sii haysto caynsanaantaada ama aad ugu hesho caawimo kharashyada. Haddii adiga, ama qof aad caawinayso, u ka qabo su'aalo arrimaha ku saabsan ogeysiiskan ama caynsanaanta qorshaha caafimaadka, waxaad ku heli kartaa caawimo iyo macluumaad luqaddaada iyada oo aan kharash kaa bixin. Si aad ula hadasho turjumaan, soo wac 1-866-251-6736 (lacag la'aan).**

**Beeksis kun waayee iyyannoo keetii ykn kan karoorri fayyaa kee qabaachuu malu odeeffannoo barbaachisaa qaba. Guyoota futuu ta'an achi keessa ilaali. Insuraansiin kee akka addaan hincinnee fi basii tokko tokkoof gargaarsa argachuudhaaf, yeroon utuu itti hindarbin tarkaanfii fudhachuu qabda . Ati ykn nami ati gargaaraa jirtu yoo waayee beeksisakana ykn karoora fayyaa kana kee hanga inni ga'u gaaffii qabaattan, kaffaltii malee gargaarsaa fi odeeffannoo afaan keessaniin argachuu dandeessu. Nama afaan isinii hiiku waliin haasa'uudhaaf 1-855-315-4016 (lak. Tolaa bilbila'a).**

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본 통지서에는 귀하의 보험 가입이나 의료 보험 적용 범위에 대한 중요한 정보가 담겨 있습니다. 본 통지서에 나와 있는 중요한 날짜를 확인해 보십시오. 귀하께서는 특정 마감 기한까지 조치를 취하셔야 계속 보험 적용을 받거나 비용 지원을 받으실 수 있습니다. 귀하 본인이나 귀하가 도와주고 있는 사람이 본 통지서나 의료 보험 적용 범위에 대한 질문이 있는 경우, 본인 비용 부담 없이 모국어로 지원 및 정보를 받으실 수 있습니다. 통역사와 통화를 하시려면, 1-855-904-2583 번(수신자 부담)으로 연락하시기 바랍니다.

**Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw ng planong pangkalusugan.** Maghanap ng mahahalagang petsa sa paunawang ito. Maaaring kailanganin mong gumawa ng aksyon sa pamamagitan ng ilang mga itinakdang panahon upang mapanatili ang iyong saklaw o makatanggap ng tulong para sa mga gastos. Kung ikaw, o ang isang tao na tinutulungan mo, ay may mga katanungan tungkol sa paunawang ito o saklaw ng planong pangkalusugan, makatatanggap ka ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang taga-interpret, tumawag sa 1-866-537-7720 (walang bayad ang toll).

**Díí éí nits'íís baa áháyá binaaltsoos dóó bee ník'i adéest'í'ígí aláahgo binahjí' ééhózinígí át'é.** Yoolkáál dabiká'ígí baa ákonínízin dooleel. Lahda t'áadoo áají' iilkááhi éí díí naaltsooshazhdiil'ííh díí shá bik'é azláadoo jinízingo. Ni éí doodagóó t'áá háida biká'anilyeedígí díí naaltsoos dóó bik'é azláhígí baah na'idíkid neehólóogo éí t'áájúik'e t'áá nizaad k'ehjí bee nilhodoonih dóó níká'adoolwołgo éí át'é. Ata' halne'é la' bichí' hadeesdih nínízingo éí 1-855-902-2583jí't'áá jíik'e béesh bee hodíílnih.

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

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## 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 **\$5,680**

■ Patient pays **\$1,860**

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinsurance	\$690
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,860</b>

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

■ Amount owed to providers: **\$5,400**

■ Plan pays **\$3,540**

■ Patient pays **\$1,860**

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$700
Coinsurance	\$80
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,860</b>

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**Questions:** Call toll-free 1-888-279-4210 or visit us at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com).

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or by calling toll-free 1-888-279-4210 to request a copy.

## Questions and answers about the Coverage Examples:

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### 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.

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### 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.

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### 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.

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### 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.

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### 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.

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### 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.

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