BlueCross BlueShield Minnesota

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WEST CENTRAL EDUCATION DISTRICT

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

Coverage Period: Beginning on or after 10/01/2018
Coverage for: Individual/Family | Plan Type:

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.bluecrossmn.com/mnservcoop or call toll-free 1-866-537-7702. 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 1-866-537-7702 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000 individual medical combined Network and Out-of-Network $2,000 family medical combined Network and Out-of-Network	Generally, you must pay all the costs up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Well-child care, prenatal care and Network Preventive care 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?	$3,000 individual medical Network $3,500 individual medical Out-of-Network $6,000 family medical Network $6,500 family medical Out-of-Network $750 individual drug combined Network and Out-of-Network $1,500 family drug combined Network	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.

	and Out-of-Network	
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.bluecrossmnonline.com/find-a-doctor/#/home or call toll-free 1-866-537-7702 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	$30 office visit copay; deductible does not apply to services subject to a copay; 20% coinsurance for all other services	40% coinsurance	----------none----------
	Specialist visit	$30 office visit copay; deductible does not apply to services subject to a copay; 20% coinsurance for all other services	40% coinsurance	----------none----------
	Preventive care/screening/ Immunization	No charge	40% coinsurance for adult preventive services No charge for well-child care services	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

If you need drugs to treat your illness or condition. 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. More information about prescription drug coverage is available at www.bluecrossmn.com/mnservcoop	Preferred generic drugs	$12.00 copay/retail $24.00 copay/mail service $24.00 copay/90dayRx Retail	$12.00 copay/retail	Covers up to 31-day supply (retail prescription) 90-day supply (mail order or 90dayRx Retail prescription). No coverage for mail order or 90dayRx Retail services from out-of-network providers.
	Preferred brand drugs	$40.00 copay/retail $80.00 copay/mail service $80.00 copay/90dayRx Retail	$40.00 copay/retail	
	Non-preferred drugs	Non-preferred generic drugs: $12.00 copay/retail $24.00 copay/mail service $24.00 copay/90dayRx Retail Non-preferred brand drugs: $90.00 copay/retail $180.00 copay/mail service $180.00 copay/90dayRx Retail	Non-preferred generic drugs: $12.00 copay/retail Non-preferred brand drugs: $90.00 copay/retail	
	Specialty drugs	$200.00 copay or 20% coinsurance, whichever is greater.	Not covered	Covers up to 31-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)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$100.00 copay/visit; deductible does not apply	$100.00 copay/visit; deductible does not apply	----------none----------
	Emergency medical transportation	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	----------none----------
	Urgent care	$30 office visit copay; deductible does not apply to services subject to a copay; 20% coinsurance for all other services	40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	----------none----------

	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 office visit copay; deductible does not apply to services subject to a copay; 20% coinsurance for all other services	40% coinsurance	Services for marriage/couples counseling are not covered.
	Inpatient services	20% coinsurance	40% coinsurance	----------none----------
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $30 office visit copay; deductible does not apply to services subject to a copay; 20% coinsurance for all other services	Prenatal care: No charge Postnatal care: 40% coinsurance	Cost sharing does not apply to certain 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 (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	----------none----------
	Rehabilitation services	20% coinsurance for occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	40% coinsurance for occupational therapy 40% coinsurance for physical therapy 40% coinsurance for speech therapy	----------none----------
	Habilitation services	20% coinsurance for occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	40% coinsurance for occupational therapy 40% coinsurance for physical therapy 40% coinsurance for speech therapy	
	Skilled nursing care	20% coinsurance	40% coinsurance	----------none----------
	Durable medical equipment	20% coinsurance	40% 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	Children's eye exam	No charge	No charge	----------none----------
	Children's glasses	Not covered	Not covered	No coverage for these services.

	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.)

- Acupuncture (except as specified in Plan benefits)
- Bariatric surgery
- Cosmetic surgery (except as specified in Plan benefits)
- Dental care (except as specified in Plan benefits)
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Hearing aids (as required by law)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (as required by law)
- 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 1-866-537-7702 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 Coverage 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 foran exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? 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 MNsure/the Marketplace.

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

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

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 yáníłt'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 page.

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 network prenatal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$30
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$800
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
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	$1,000
Copayments	$60
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,360**

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (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.

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

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