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

# New Prague ISD #721

**Coverage Period: Beginning on or after 07-01-2013**

**Summary of Benefits and Coverage:** What this Plan covers & What it Costs **Coverage for:** Single and family coverage | **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/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? | $500 per person all providers<br>$1,000 per family all providers | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. 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. |
| Are there other deductibles for specific services? | 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. |
| Is there an out-of-pocket limit on my expenses? | Yes.<br>$1,200 medical per person all providers<br>$2,400 medical per family all providers<br>$300 per person all providers for prescription drugs<br>$500 per family all providers for prescription drugs | 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 |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| | | 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, 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% coinsurance | 20% coinsurance | _____none_____ |
| | Specialist visit | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Other practitioner office visit | 20% coinsurance for Chiropractors | 20% coinsurance for Chiropractors | _____none_____ |
| | Preventive care/screening/immunization | 0% coinsurance | 0% coinsurance | _____none_____ |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% 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>More information about prescription drug coverage is available at www.bluecrossmn.com/mnservcoop. | Generic drugs | $8.00 copay for retail drugs<br>$16.00 copay mail order drugs | $8.00 copay for retail drugs<br>Not covered mail order drugs | No coverage for mail order drugs for Out-of-Network providers. Cost sharing for non-preferred generic retail and mail order drugs is not displayed. |
| | Preferred brand drugs | $16.00 copay for retail drugs<br>$32.00 copay mail order drugs | $16.00 copay for retail drugs<br>Not covered mail order drugs | No coverage for mail order drugs from Out-of-Network providers. |
| | Non-preferred brand drugs | $32.00 copay for retail drugs<br>$64.00 copay mail order drugs | $32.00 copay for retail drugs<br>Not covered mail order drugs | No coverage for mail order drugs from Out-of-Network providers. |
| | 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) | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Physician/surgeon fees | 20% coinsurance | 20% 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 | 20% coinsurance | 20% coinsurance | _____none_____ |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Physician/surgeon fee | 20% coinsurance | 20% coinsurance | _____none_____ |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Substance use disorder outpatient services | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Substance use disorder inpatient services | 20% coinsurance | 20% 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 are pregnant | Prenatal and postnatal care | 0% coinsurance | 0% coinsurance | _____none_____ |
| | Delivery and all inpatient services | 20% coinsurance | 20% coinsurance | _____none_____ |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 20% coinsurance | _____none_____ |
| | Rehabilitation services<br>Habilitation services | 20% coinsurance for occupational therapy<br>20% coinsurance for physical therapy<br>20% coinsurance for speech therapy | 20% coinsurance for occupational therapy<br>20% coinsurance for physical therapy<br>20% coinsurance for speech therapy | _____none_____ |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 120 day maximum applies for all networks. |
| | Durable medical equipment | 20% coinsurance | 20% 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 | 0% coinsurance | 0% coinsurance | _____none_____ |
| | Glasses | 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<br>• Dental Care<br>• Long-Term Care<br>• Routine foot care<br>• Weight loss programs | • Acupuncture (subject to coverage limitations)<br>• Bariatric surgery<br>• Chiropractic Care<br>• Hearing aids (as required by Minnesota State law)<br>• Infertility treatment<br>• Most non-emergency care when traveling outside the U.S. |

| **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.) |
|---|---|
| | • Private-duty nursing<br>• 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 my 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.

## 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 |
| 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 $6,180**
- **Patient pays $1,360**

| **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 | $500 |
| Copays | $10 |
| Coinsurance | $700 |
| Limits or exclusions | $150 |
| Total | $1,360 |

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,070**
- **Patient pays $1,330**

| **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 | $500 |
| Copays | $310 |
| Coinsurance | $440 |
| Limits or exclusions | $80 |
| Total | $1,330 |

# 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 an excluded or preexisting condition.
- 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?

ûNo. 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?

ûNo. 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?

üYes. 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?

üYes. 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.