

PEIP Advantage HSA Family Plan Cost Level 2

Coverage Period: Beginning on or after 1-01-2018

Administered by:

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

Blue Cross Blue Shield of Minnesota

Coverage for: Family Coverage Only | Plan Type: Tiered Network



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/segip or by calling (651) 662-9930 or toll-free 1-866-286-2948.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | <p>\$3,200 medical and drug per family member In-Network</p> <p>\$2,600 medical and drug per family member Out-of-Network</p> <p>\$4,000 medical and drug per family In-Network</p> <p>\$3,000 medical and drug per family Out-of-Network</p> <p>Out-of-Network coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plan.</p> | 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 1 st). 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? | <p>Yes.</p> <p>\$5,000 medical and drug per family member all providers</p> <p>\$6,000 medical and drug per family all providers</p> | 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, 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 <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 www.bluecrossmn.com/segip or call (651) 662-9930 or toll-free 1-866-286-2948 | 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 . |

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| | | |
|--|---|--|
| Do I need a referral to see a specialist? | Yes. You may see certain specialists without a referral (e.g. pediatrician, mental health, chemical health, vision care, chiropractic, OB/Gyn providers). | The plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| 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.
- **Out of Network** coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area.

| 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 | \$50 copay/visit | 30% coinsurance | _____none_____ |
| | Specialist visit | \$50 copay/visit | 30% coinsurance | _____none_____ |
| | Other practitioner office visit | \$50 copay/visit for Chiropractors | 30% coinsurance for Chiropractors | _____none_____ |
| | Preventive care/screening/immunization | 0% coinsurance | 30% coinsurance | No deductible applies in network. |
| If you have a test | Diagnostic test (x-ray, blood work) | 0% coinsurance when related to an office visit; 25% coinsurance when unrelated to an office visit | 30% coinsurance | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 30% 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com . | Generic drugs | \$25 copay | No coverage | Some preferred brand drugs are included in this tier. Diabetic supplies at 80%. |
| | Preferred brand drugs | \$40 copay | No coverage | Some preferred brand drugs are included in this tier. Diabetic supplies at 80%. |
| | Non-preferred brand drugs | \$65 copay | No coverage | Diabetic supplies at 80%. |
| | Specialty drugs | Pays at the copay level associated with the formulary status of the specialty drug. | No coverage | For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$400 copay/surgical session; | 30% coinsurance | _____none_____ |
| | Physician/surgeon fees | 0% coinsurance | 30% coinsurance | _____none_____ |
| If you need immediate medical attention | Emergency room services | \$150 copay/visit | \$150 copay/visit | _____none_____ |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | _____none_____ |
| | Urgent care | \$50 copay/visit | \$50 copay/visit | _____none_____ |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$650 copay/admission | 30% coinsurance | _____none_____ |
| | Physician/surgeon fee | 0% coinsurance | 30% coinsurance | _____none_____ |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$50 copay/visit in an office; 25% coinsurance in a facility | 30% coinsurance | _____none_____ |
| | Mental/Behavioral health inpatient services | \$650 copay/admission | 30% coinsurance | _____none_____ |
| | Substance use disorder outpatient services | \$50 copay/visit in an office; 25% coinsurance in a facility | 30% coinsurance | _____none_____ |
| | Substance use disorder inpatient services | \$650 copay/admission | 30% 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 | 0% coinsurance | 30% coinsurance | No deductible applies in network to prenatal services. |
| | Delivery and all inpatient services | \$650 copay/admission | 30% coinsurance | _____none_____ |
| If you need help recovering or have other special health needs | Home health care | 25% coinsurance | 30% coinsurance | _____none_____ |
| | Rehabilitation services Habilitation services | \$50 copay/visit for occupational therapy \$50 copay/visit for physical therapy \$50 copay/visit for speech therapy | 30% coinsurance for occupational therapy 30% coinsurance for physical therapy 30% coinsurance for speech therapy | _____none_____ |
| | Skilled nursing care | 0% coinsurance | 30% coinsurance | _____none_____ |
| | Durable medical equipment | 25% coinsurance | 30% coinsurance | _____none_____ |
| | Hospice service | 0% coinsurance | 30% coinsurance | Maximums apply. Refer to your plan document for details. |
| | | | | |
| If your child needs dental or eye care | Eye exam | 0% coinsurance | 30% coinsurance | No deductible applies in network. |
| | 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 <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"> • Cosmetic surgery • Dental Care • Infertility treatment • Long-Term Care • Most non-emergency care when traveling outside the U.S. • Routine foot care | <ul style="list-style-type: none"> • Acupuncture (subject to coverage limitations) • Bariatric surgery • Chiropractic Care • Hearing aids • Private-duty nursing • Routine eye care (Adult) |

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| | |
|--|--|
| 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"> Weight loss programs | |

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) 662-9930 or toll-free 1-866-286-2948.

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) 296-4026 or toll-free 1-800-657-3602. If you are covered under a plan offered by a city, county, or school district, 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 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.**

Language Access Services:

| | |
|---|----------------|
| Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 | 1-866-286-2948 |
| Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' | 1-866-286-2948 |
| Spanish (Español): Para obtener asistencia en Español, llame al | 1-866-286-2948 |
| Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa | 1-866-286-2948 |

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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 **\$3,340**

■ Patient pays **\$4,200**

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 | \$3,200 |
| Copays | \$670 |
| Coinsurance | \$180 |
| Limits or exclusions | \$150 |
| Total | \$4,200 |

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

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

■ Plan pays **\$1,380**

■ Patient pays **\$4,020**

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 | \$3,200 |
| Copays | \$590 |
| Coinsurance | \$150 |
| Limits or exclusions | \$80 |
| Total | \$4,020 |

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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?

✗ **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.

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