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

3M Choice Advantage Plan

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

Summary of Benefits and Coverage: What this Plan covers & What it Costs **Coverage for:** Single and family coverage | **Plan Type:** HSA

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) 662-5510 or toll-free 1-800-858-0722.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,600** per person In-Network **$5,200** per family In-Network **$5,200** per person Out-of-Network **$10,400** per family Out-of-Network	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 or 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. **$5,200** medical and drug per person In-Network **$10,400** medical and drug per family In-Network **$10,400** medical and drug per person Out-of-Network **$20,800** medical and drug per family 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, hearing aids 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** or call (651) 662-5510 or toll-free 1-800-858-0722	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.**

Important Questions	Answers	Why this Matters:
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	10% coinsurance	35% coinsurance	_____none_____
	Specialist visit	10% coinsurance	35% coinsurance	_____none_____
	Other practitioner office visit	10% coinsurance for Chiropractors	35% coinsurance for Chiropractors	Coverage is limited to a maximum 25 visits combined in and out of network for chiropractor and 25 visits combined in and out of network for acupuncture per calendar year. Refer to your plan document for details.
	Preventive care/screening/immunization	0% coinsurance	35% coinsurance	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	35% 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
	Imaging (CT/PET scans, MRIs)	10% coinsurance	35% coinsurance	_____none_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	10% retail 10% mail order	35% retail 35% mail order	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Preferred brand drugs	10% retail 10% mail order	35% retail 35% mail order	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Non-preferred brand drugs	10% mail order	35% mail order	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Specialty drugs	Refer to the applicable prescription drug cost sharing.	Not covered	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)	10% coinsurance	35% coinsurance	_____none_____
	Physician/surgeon fees	10% coinsurance	35% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	_____none_____
	Emergency medical transportation	10% coinsurance	10% coinsurance	_____none_____
	Urgent care	10% coinsurance	10% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	35% coinsurance	_____none_____
	Physician/surgeon fee	10% coinsurance	35% coinsurance	_____none_____
If you have mental health, behavioral	Mental/Behavioral health outpatient services	10% coinsurance	35% 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
health, or substance abuse needs	Mental/Behavioral health inpatient services	10% coinsurance	35% coinsurance	_____none_____
	Substance use disorder outpatient services	10% coinsurance	35% coinsurance	_____none_____
	Substance use disorder inpatient services	10% coinsurance	35% coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	0% coinsurance	35% coinsurance	Screenings for pregnant women which are included in new Federal preventive care guidelines are covered at 100%.
	Delivery and all inpatient services	10% coinsurance	35% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	10% coinsurance	35% coinsurance	_____none_____
	Rehabilitation services Habilitation services	10% coinsurance for occupational therapy 10% coinsurance for physical therapy 10% coinsurance for speech therapy	35% coinsurance for occupational therapy 35% coinsurance for physical therapy 35% coinsurance for speech therapy	_____none_____
	Skilled nursing care	10% coinsurance	35% coinsurance	90 day maximum applies for all networks.
	Durable medical equipment	10% coinsurance	35% coinsurance	Hearing aids are covered up to $750 per ear every 3 years
	Hospice service	10% coinsurance	35% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	0% coinsurance	35% coinsurance	Coverage for routine eye care is available through VSP
	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 • Dental Care • Long Term Care • Private-duty nursing • Routine eye care (Adult) coverage for routine eye care is available through VSP • Routine foot care	• Acupuncture (subject to coverage limitations) • Bariatric surgery • Chiropractic Care • Hearing aids • Hospice • Infertility treatment

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) 662-5510 or toll-free 1-800-858-0722. 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

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.

Language Access Services:

Chinese (中文): 如果需要中文的帮助，请拨打这个号码	1-800-858-0722
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-858-0722
Spanish (Español): Para obtener asistencia en Español, llame al	1-800-858-0722
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-858-0722

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 $4,440**
- **Patient pays $3,100**

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	$2,600
Copays	$0
Coinsurance	300
Limits or exclusions	$200
Total	**$3,100**

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

- **Amount owed to providers: $5,400**
- **Plan pays $2,420**
- **Patient pays $2,980**

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	$2,600
Copays	$0
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,980**

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.