BlueCross BlueShield Minnesota

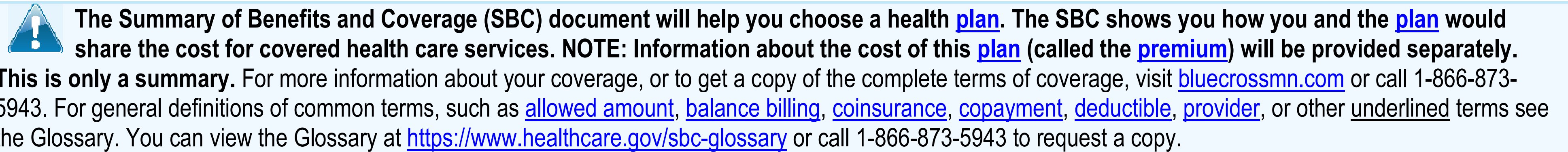
Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2024

T24050 Aware $2,000 Ded 30% Coins Copay Plan

Coverage for: Individual/Family | Plan Type: PPO



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 bluecrossmn.com or call 1-866-873-5943. 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 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 individual / $6,000 family medical in-network $5,000 individual / $10,000 family medical out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well child care, prenatal care and in-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?	$4,500 individual / $9,000 family medical and drug in-network $10,000 individual / $20,000 family medical and drug out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), 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 an in-network provider?	Yes. Your network is Aware. See bluecrossmn.com/find-a-doctor/#/home or call 1-866-873-5943 for a list of in-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 in-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
		In-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 or illness	$40 copay/office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	None
	Specialist visit	$40 copay/office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	May require prior authorization.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at bluecrossmn.com	Tier 1 drugs	$20.00 copay, deductible does not apply/prescription (retail) $60.00 copay, deductible does not apply/prescription (mail service) $60.00 copay, deductible does not apply/prescription (90dayRx retail)	Not covered	Covers up to a 31-day supply (retail prescription); 90-day supply (mail service prescription and 90dayRx retail prescription). Insulin listed on Tier 1 and Tier 3 of the covered drug list are covered at zero cost-sharing. The value of drug coupons you use will not count towards cost-sharing or out-of-pocket limits May require prior authorization.
	Tier 2 drugs	$50.00 copay, deductible does not apply/prescription (retail) $150.00 copay, deductible does not apply/prescription (mail service) $150.00 copay, deductible does not apply/prescription (90dayRx retail)	Not covered	
	Tier 3 drugs	$75.00 copay, deductible does not apply/prescription (retail) $225.00 copay, deductible does not apply/prescription (mail service) $225.00 copay, deductible does not apply/prescription (90dayRx retail)	Not covered	
	Tier 4 drugs	$120.00 copay, deductible does not apply/prescription (retail) $360.00 copay, deductible does not apply/prescription (mail service) $360.00 copay, deductible does not apply/prescription (90dayRx retail)	Not covered	
	Specialty drugs	30% coinsurance, deductible does not apply up to a maximum of $550	Not covered	Covers up to a 31-day supply (participating specialty drug network supplier prescription).

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$40 copay/office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance use services	Outpatient services	$40 copay/office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	Services for marriage/couples counseling are not covered. May require prior authorization.
	Inpatient services including adult mental health treatment	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $40 copay/office visit, deductible does not apply; 30% coinsurance for all other services	Prenatal care: No charge Postnatal care: 50% coinsurance	Cost-sharing does not apply for 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 (e.g., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	May require prior authorization.

Common Medical Event	Services You May Need	What you Will Pay: In-Network Provider (You will pay the least)	What you Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	30% coinsurance for occupational therapy, physical therapy, and speech therapy	50% coinsurance for occupational therapy, physical therapy, and speech therapy	May require prior authorization.
	Habilitation services	30% coinsurance for occupational therapy, physical therapy, and speech therapy	50% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	30% coinsurance	50% coinsurance	Combined 120 days per person per benefit period. May require prior authorization.
	Durable medical equipment	30% coinsurance	50% coinsurance	May require prior authorization.
	Hospice service	30% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Age 0 through 5: No charge Age 6 through 18: 50% coinsurance	None
	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check-up	Not covered	Not covered	No coverage for these services

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (and children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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
- 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: Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or 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. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.mnsure.com or call 1-855-366-7873.

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: Blue Cross at 1-866-873-5943; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standards? 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 the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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, copayment 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 in-network prenatal care and a hospital delivery)

- The plan's overall deductible **$2,000**
- Specialist copayment **$40**
- Hospital (facility) coinsurance **30%**
- Other coinsurance **30%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,470**

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

- The plan's overall deductible **$2,000**
- Specialist copayment **$40**
- Hospital (facility) coinsurance **30%**
- Other coinsurance **30%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- The plan's overall deductible **$2,000**
- Specialist copayment **$40**
- Hospital (facility) coinsurance **30%**
- Other coinsurance **30%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

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.

နမ့်ကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, 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.

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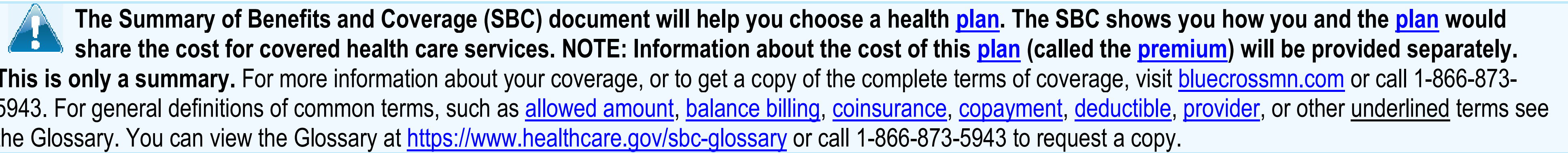
T24100P Aware HSA $4,500 Ded 25% Coins Preventive Rx Plan | **Coverage for: Individual/Family | Plan Type: PPO**



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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?	$8,050 individual / $16,100 family medical and drug in-network $12,500 individual / $25,000 family medical and drug out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Specialist visit	25% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	May require prior authorization.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at bluecrossmn.com	Tier 1 drugs	25% coinsurance/prescription (retail) 25% coinsurance/prescription (mail service) 25% coinsurance/prescription (90dayRx retail)	Not covered	Covers up to a 31-day supply (retail prescription); 90-day supply (mail service prescription and 90dayRx retail prescription). Insulin listed on Tier 1 and Tier 3 of the covered drug list are covered at zero cost-sharing. The value of drug coupons you use will not count towards cost-sharing or out-of-pocket limits May require prior authorization.
	Tier 2 drugs	25% coinsurance/prescription (retail) 25% coinsurance/prescription (mail service) 25% coinsurance/prescription (90dayRx retail)	Not covered	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 3 drugs	25% coinsurance/prescription (retail) 25% coinsurance/prescription (mail service) 25% coinsurance/prescription (90dayRx retail)	Not covered	
	Tier 4 drugs	25% coinsurance/prescription (retail) 25% coinsurance/prescription (mail service) 25% coinsurance/prescription (90dayRx retail)	Not covered	
	Specialty drugs	25% coinsurance	Not covered	Covers up to a 31-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	25% coinsurance	25% coinsurance	
	Urgent care	25% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fee	25% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance use services	Outpatient services	25% coinsurance	50% coinsurance	Services for marriage/couples counseling are not covered. May require prior authorization.
	Inpatient services including adult mental health treatment	25% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: 25% coinsurance	Prenatal care: No charge Postnatal care: 50% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, other cost-sharing may apply. Maternity care may include
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	tests and services described elsewhere in the SBC (e.g., ultrasound).
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	May require prior authorization.
	Rehabilitation services	25% coinsurance for occupational therapy, physical therapy, and speech therapy	50% coinsurance for occupational therapy, physical therapy, and speech therapy	May require prior authorization.
	Habilitation services	25% coinsurance for occupational therapy, physical therapy, and speech therapy	50% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	25% coinsurance	50% coinsurance	Combined 120 days per person per benefit period. May require prior authorization.
	Durable medical equipment	25% coinsurance	50% coinsurance	May require prior authorization.
	Hospice service	25% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Age 0 through 5: No charge Age 6 through 18: 50% coinsurance	None
	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check-up	Not covered	Not covered	No coverage for these services

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (and children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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
- 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: Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA

(3272) or www.dol.gov/ebsa/healthreform; or 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. For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.mnsure.com or call 1-855-366-7873.

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: Blue Cross at 1-866-873-5943; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standards? 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 the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-902-2583.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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, copayment 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 in-network prenatal care and a hospital delivery)

- The plan's overall deductible **$4,500**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,960**

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

- The plan's overall deductible **$4,500**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

- The plan's overall deductible **$4,500**
- Specialist coinsurance **25%**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	**$2,800**

In this example, Mia would pay:

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

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

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.

နမ့်ကတိၤကညီကျိာ်ဒီး, တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, 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.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

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.

2024 Blue Cross Dental
Plan 1: Freedom Enhanced

Abbey Care inc
Effective Date : January 1, 2024

PLAN BENEFITS	IN NETWORK Advantage Plus AXS	OUT OF NETWORK 90th Percentile
Calendar year deductible Deductible does not apply to preventive and diagnostic services, orthodontia, services covered at 100%	Individual/Family: $50/$150	Individual/Family: $50/$150
Annual maximum per member	$1,500	$1,500
Preventive incentive: Preventive and diagnostic services are not applied to the annual maximum	Not Included	Not Included
Orthodontic lifetime maximum **Dependent children to age 19**	$1,500	$1,500
PREVENTIVE AND DIAGNOSTIC		
Exams	100%	100%
Cleanings	100%	100%
Fluoride treatments	100%	100%
X-rays (bitewings and full mouth)	100%	100%
Sealants	100%	100%
BASIC RESTORATIVE		
Amalgam (silver) fillings	80%	80%
Composite (white) fillings	80%	80%
Surgical periodontics Includes treatment of gum disease	80%	80%
Non-surgical periodontics Includes treatment of gum disease	80%	80%
Endodontics Includes root canal	80%	80%
Simple extractions	80%	80%
Complex oral surgery	80%	80%
General anesthesia	80%	80%
Repairs Includes bridges and dentures	80%	80%
MAJOR		
Implants	Not Covered	Not Covered
Inlays and onlays	50%	50%
Crowns	50%	50%
Prosthetics Includes bridges and dentures	50%	50%
TMD (temporomandibular disorder)	50%	50%
ORTHODONTICS		
Diagnostic, active, retention, treatment	50%	50%

Out-of-Network (OON) services covered at Usual, Customary, and Reasonable 90th level.

When you receive services from nonparticipating providers, you are responsible for the difference between the allowed amount and the billed charge.

This plan provides dental coverage only. Your dental plan’s benefit booklet will provide a detailed description of the coverage and contain more details on standard plan exclusions and frequency limitations. In the event of a discrepancy, the benefit booklet will supersede this summary.

Consult our online provider directory at bluecrossmn.com/findadentist to search for a dentist. Dentists with a “**$AVE!**” symbol next to their name accept allowances for services not covered by the benefit plan, including services rendered after the annual maximum has been exceeded; not available in all areas.

Blue Cross Dental plans include coverage for certain pediatric dental services. This plan is not exchange-certified and does not qualify as the pediatric dental essential health benefit under the Affordable Care Act.

United Concordia Companies, Inc. is an independent company providing dental benefit management services and access to the Advantage Plus AXS network.

Each provider in the network is an independent contractor and is not our agent.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

BENEFIT CATEGORY	STANDARD FREQUENCY LIMITATIONS
CLASS I: PREVENTIVE	
Exams	2 per calendar year
X-rays (bitewings only)	1 set every 12 months under age 19; 1 set every 18 months age 19 and over
X-rays (full mouth and panoramic)	1 every 5 years
Cleanings	2 per calendar year
Fluoride treatment	1 per calendar year under age 14
Space maintainers	1 every 5 years under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
CLASS II: BASIC	
Amalgam (silver) and composite (white) fillings	Not within 24 months of previous placement. Includes coverage for anterior (front) and posterior (back) resins
Endodontics	• Pulpal therapy: primary teeth that have no permanent tooth to replace it • Root canal treatment: 1 per tooth per lifetime
Non-surgical periodontics	• Full mouth debridement: 1 per lifetime • Scaling and root planing: 1 per 24 months (per area of mouth) • Periodontal maintenance: 2 per calendar year (in addition to routine prophylaxis following active periodontal therapy)
Surgical periodontics	• Surgical periodontal procedures: 1 per 36 months (per area of mouth) • Guided tissue regeneration: 1 per tooth per lifetime
General anesthesia	Limited to 60 minutes per session
CLASS III: MAJOR	
Implants	Not Covered
Inlays and onlays	Not within 5 years of previous placement
Crowns	Not within 5 years of previous placement
Prosthetics (bridges and dentures)	Not within 5 years of previous placement
ORTHODONTICS	
Dependent children to age 19	
DEPENDENT ELIGIBILITY	
Dependent children covered to age 26	

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

BLUE CROSS VISION

Value Standard Option 1

Regular eye exams: A window to your health.

Ninety million Americans over 40 have vision and eye problems.[1] Your Blue Cross Vision plan includes benefits to help keep you and your wallet healthy, including:

- 100 percent coverage for routine eye exam after a small copay
- No waiting period
- Coverage for eyeglasses or contact lenses
- Scratch-resistant coating and tinting of plastic lenses
- Blue light lens coverage — to protect your eyes from harmful blue light emitted from electronic devices
- Discounts on Davis Vision Exclusive Collection frames (private practice providers)
- Enhanced benefits at Visionworks
- Traditional LASIK discounts of up to 50 percent[2]

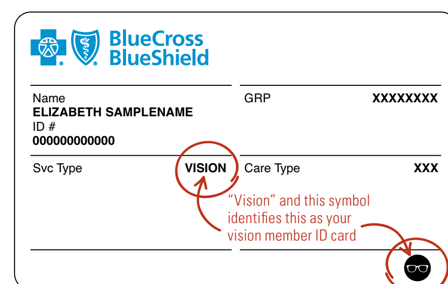
THE BLUE CROSS DIFFERENCE

As a Blue Cross member, you get these exclusive benefits:

- Fixed lens pricing on all plans — members pay the same no matter where they go in network
- Free one-year breakage warranty
- Discounts on a second pair of eyewear with in-network providers

VISION ID CARD: YOUR ACCESS TO EYE CARE

If you have a Blue Cross and Blue Shield of Minnesota medical plan, you will have a member ID card for your vision plan and a separate ID card for your medical plan. Use your vision member ID card when you want to access benefits through your vision plan.



[1]Centers for Disease Control and Prevention, 2021.

[2]Laser vision correction services administered by QualSight, LLC®. Terms and savings are subject to change. QualSight is an independent company that does not offer Blue Cross products or services. QualSight is solely responsible for its products and services.

[3]Centers for Disease Control and Prevention, 2021.

FIND AN EYECARE PROVIDER

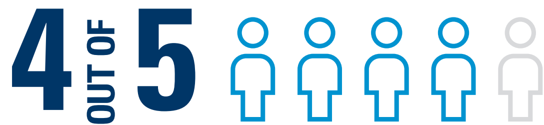
Blue Cross Vision plans use the Davis Vision network, a national network of private practices and retail locations.[1] You have access to more than 1,900 locations in Minnesota and more than 124,000 locations nationwide.[2] Some of the additional retail locations and online providers include:

Retail locations

- Target Optical
- Pearle Vision
- America's Best
- JCPenney Optical
- Shopko Optical

Online providers

- 1800Contacts.com
- glasses.com
- befitting.com

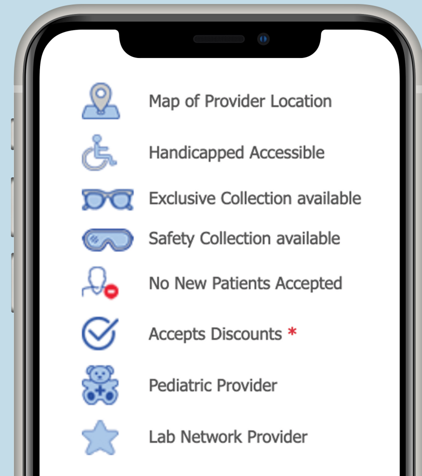


TOP OPTICAL RETAILERS PARTICIPATE

including Visionworks, Costco, Walmart and Sam's Club[3]

Your medical plan and your vision plan have two different networks. To find a provider for your Blue Cross Vision plan, visit **bluecrossmn.com/findaneyedoctor.**

When searching for a provider, you can filter the search based on specialty, where the provider is located, what collections they offer and types of discounts.



[1]Davis Vision is an independent company providing vision benefit management services and access to their network. Each vision provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

[2]Davis Vision, 2022.

[3]Retail partners of Davis Vision.

2024 Blue Cross Vision
Value Standard Exam and Eyewear – Option 1

	In-network benefit	Out-of-network reimbursements
EYE EXAMS – One exam every 12 months		
Eye exam Includes dilation when recommended by eye care professional	100% after $10 copay	$40
PRESCRIPTION GLASSES – Benefit available for eyeglass lenses *or* contact lenses once every 12 months		
Lenses* Single vision, lined bifocal, trifocal, lenticular, polycarbonate (dependent children)	100% after $25 copay	Single vision: $40 Bifocal/progressive: $60 Trifocal: $80 Lenticular: $100
Frames	1 every 12 months	$50
Davis Vision Exclusive Collection** - Fashion level - Designer level - Premier level	 100%; no copay 100%; no copay 100%; $25 copay	
Non-Davis Vision Exclusive Collection - Visionworks stores - Frames available from other participating retailers	No copay: plan pays up to $180 plus 20% discount on remaining costs*** No copay: plan pays up to $130 plus 20% discount on remaining costs***	
EYE GLASS ENHANCEMENTS		
- Tinting of plastic lenses	Member pays $0	Not Covered
- Scratch-resistant coating	Standard: $0 / Premium: $30	
- Polycarbonate lenses - Dependent children, monocular patients and those with a prescription of +/-6.00 diopters or greater - Adults	 Member pays $0 Member pays $30	
- Ultraviolet coating	Member pays $12	
- Anti-reflective coating	Standard: $35 / Premium: $48 / Ultra: $60 / Ultimate: $85	
- Blue light filtering	Member pays $15	
- Progressive lenses	Standard: $50 / Premium: $90 / Ultra: $140 / Ultimate: $175	
- High-index lenses	Member pays $55 / $120	
- Polarized lenses	Member pays $75	
- Plastic photochromic lenses	Member pays $65	
- Scratch protection plan	Single vision: $20 / Multifocal vision: $40	
CONTACT LENSES – Benefit available for eyeglass lenses *or* contact lenses once every 12 months		
Collection contact lenses† - Disposable - Non-disposable	 up to 4 boxes up to 2 boxes	Not Applicable
- Evaluation, fitting and follow-up care	100% after $25 copay	Not Applicable
Non-collection contact lens allowance††	Plan pays up to $130 plus 15% discount on remaining costs***	$105
- Evaluation, fitting and follow-up care for standard lenses - Evaluation, fitting and follow-up care for specialty lenses	100% after $25 copay $25 copay; after copay, plan pays up to $60 plus 15% discount on remaining costs***	Not Covered

*Your plan covers a wide variety of lenses. Be sure the lenses you choose are covered by your plan. You'll have to pay the full cost for lenses your plan doesn't cover. Your eyecare/eyewear provider can assist you with this, or you can contact customer service at the number on your vision member ID card.

**Davis Vision Exclusive Collection available at most participating independent provider offices. Collection is subject to change.

***Additional discount not available at Costco, Walmart, Sam's Club or at participating online retail providers.

†Available at most participating independent provider offices. Collection is subject to change.

††Available at participating retail providers.

This plan provides vision coverage only. Your vision plan's benefit booklet will contain more details on standard plan exclusions and frequency limitations. In the event of a discrepancy, the benefit booklet will supersede this summary.

Davis Vision is an independent company providing vision benefit management services and access to their network. Each provider in the network is an independent contractor and is not our agent. If you receive services from a nonparticipating provider, you will be responsible for the difference between what Blue Cross will reimburse and what the provider bills.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

BlueCross BlueShield Minnesota

BLUE CROSS VISION PLAN

Frequently asked questions

Welcome to your Blue Cross Vision plan.

Thank you for choosing Blue Cross and Blue Shield of Minnesota for your vision benefits. We're looking forward to serving you and want to get you off to a great start as a plan member. Here are answers to some questions you may have about your vision plan.

Q. DO MY MEDICAL PLAN AND MY STAND-ALONE VISION PLAN USE THE SAME NETWORK?

Your medical and your vision plan have two different networks.

Q. HOW DO I FIND AN EYE CARE PROFESSIONAL IN THE NETWORK?

As a Blue Cross Vision plan member, you'll have access to the Davis Vision network. To find an in-network vision provider, visit **bluecrossmn.com/FindAnEyeDoctor**. When searching for a provider, you can filter the search based on specialty, where the provider is located, what collections they offer and types of discounts.

Q. WHAT IF MY PROVIDER IS NOT IN NETWORK?

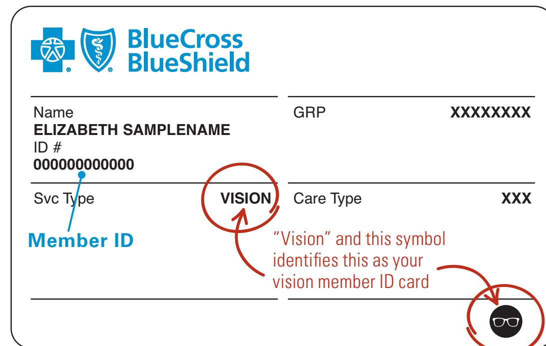
Your plan will provide a set amount for reimbursement of frames, eyeglass lenses or contact lenses when your provider is not in network. You will need to submit a claim form to receive reimbursement.

Q. WHAT INFORMATION WILL MY EYE CARE PROVIDER NEED FROM ME?

When scheduling an appointment, you will need to have your vision member ID number ready. This number is on your vision ID card. When you arrive at your appointment you'll need to present your vision ID card, and let them know your vision plan is through Blue Cross and administered by Davis Vision.

Q. WHERE CAN I FIND MY MEMBER ID NUMBER?

Your member ID number is on the front of your vision ID card under your name.



Q. I HAVE A MATERIALS-ONLY VISION PLAN. HOW DO I ACCESS MY EYE EXAM BENEFITS?

If you have a vision plan that only covers materials (glasses and contact lenses), you will need to confirm your eye exam benefits and network with your medical plan.

Q. DOES MY PLAN INCLUDE AN EYE EXAM? IF SO, WHAT IS AN EXAM COPAY?

Some plans do not include an exam, but do include discounts on eyeglasses and contact lenses. An exam copay (or copayment) is a set fee you pay for a visit with an eye care professional. Typically you pay your copay at the time of the appointment.

Q. WHAT IS A FRAME ALLOWANCE?

A frame allowance is the amount your plan will pay toward your eyeglass frames. You will be responsible to pay any remaining amount.

Q. WHERE CAN I FIND THE DAVIS VISION EXCLUSIVE COLLECTION OF FRAMES?

The Davis Vision Exclusive Collection is a collection of more than 200 frames valued up to $195. You can choose from the Fashion level, Designer level or Premier level. This collection is available at most in-network private practice providers. If you choose not to purchase from the collection, you can still use the frame allowance.

Davis Vision Exclusive Collection is available at most independent providers and private practice locations. Collection is subject to change.

Q. WHERE CAN I FIND THE NON-DAVIS VISION EXCLUSIVE COLLECTION OF FRAMES?

The non-Davis Vision Exclusive Collection of frames is available at in-network retailers. Your frame allowance will be higher when you purchase your frames from a Visionworks store. You will automatically receive the frame allowance increase.

Q. WHAT IS AN EYEGLASS ENHANCEMENT?

Typical enhancements are lens coatings and lens types such as blue light filtering, scratch-resistant and antireflective coatings, and polarized and progressive lenses. There is a copay for each enhancement. You will be responsible for the additional costs above what the plan pays.

Q. WHAT IS THE DIFFERENCE BETWEEN DAVIS VISION COLLECTION CONTACT LENSES AND NON-COLLECTION?

Collection contact lenses can be found at many in-network private practice providers. Non-collection lenses are available at all in-network retail providers. Both options include popular contact lens brands.

Q. CAN I GET MY CONTACT LENS EVALUATION AND FITTING DURING MY ROUTINE EYE EXAM?

A contact lens evaluation and fitting is a separate service from a routine exam. There is a separate copay for your contact lens evaluation and fitting.

Q. CAN I GET GLASSES AND CONTACT LENSES IN THE SAME YEAR?

Your plan will cover eyeglass lenses *or* contact lenses, but not both. Discounts on additional pairs of eyeglasses may be available from some in-network providers.

Q. CAN I USE MY VISION PLAN BENEFITS TO PURCHASE MY GLASSES OR CONTACT LENSES ONLINE?

Yes, in-network benefits are available online at participating providers like 1800contacts.com, glasses.com and befitting.com. If you choose to order your contacts or glasses online from a nonparticipating provider you will need to submit a claim form for reimbursement.

Q. ARE MEDICAL CONDITIONS LIKE GLAUCOMA AND CATARACTS COVERED UNDER MY VISION PLAN?

No, these conditions are typically covered under a standard medical plan.

Q. HOW DO I OBTAIN A DISCOUNT ON LASIK PROCEDURES?

LASIK discounts are offered through QualSight LLC®. In order to access these discounts, please contact QualSight by calling 1-855-502-2020 or visiting lasik.qualsight.com.

Davis Vision is an independent company providing vision benefit management services and access to the Davis network. Each vision provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

Laser vision correction services administered by QualSight, LLC®. Terms and savings are subject to change. QualSight is an independent company that does not offer Blue Cross products or services. QualSight is solely responsible for its products and services.

Your plan covers a wide variety of lenses. Be sure the lenses you choose are covered by your plan. You'll have to pay the full cost for lenses your plan doesn't cover. Your eye care/eyewear provider can assist you with this, or you can contact customer service at the number on your vision member ID card.

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