




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, call 952-854-0795. 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 www.healthcare.gov/sbc-glossary or call 952-854-0795 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$250 person/\$750 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , Doctor on Demand, orthotics (up to \$400), and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$200 person/visit for emergency room services. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$2,000 (plus \$250 <u>deductible</u>) person/\$6,000 (plus \$750 <u>deductible</u>) family; Prescription Drugs: \$4,900 person/\$7,550 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.bluecrossmn.com/healthy/public/personal/home for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Doctor on Demand telehealth benefits are not subject to the <u>deductible</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	There is no charge for age-appropriate <u>preventive services</u> required by the health reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes X-rays used for therapeutic treatment.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.express-scripts.com/ .	Generic drugs	\$5 <u>copay</u> /prescription retail; \$10 <u>copay</u> /prescription mail order. <u>Deductible</u> does not apply.	\$5 <u>copay</u> /prescription retail; \$10 <u>copay</u> /prescription mail order. <u>Deductible</u> does not apply.	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). Erectile dysfunction drugs limited to 12 pills per month. No charge for ACA-required generic preventive drugs (or brand drug if generic is not medically appropriate).
	Preferred brand drugs	20% <u>coinsurance</u> (retail and mail order); \$20 minimum <u>copay</u> /script (retail)/\$70 maximum <u>copay</u> /script (retail); \$40 minimum <u>copay</u> /script (mail order)/\$140 maximum <u>copay</u> /script (mail order). <u>Deductible</u> does not apply.	20% <u>coinsurance</u> (retail and mail order); \$20 minimum <u>copay</u> /script (retail)/\$70 maximum <u>copay</u> /script (retail); \$40 minimum <u>copay</u> /script (mail order)/\$140 maximum <u>copay</u> /script (mail order). <u>Deductible</u> does not apply.	
	Non-preferred brand drugs	20% <u>coinsurance</u> (retail and mail order); \$20 minimum <u>copay</u> /script (retail)/\$70 maximum <u>copay</u> /script (retail); \$40 minimum <u>copay</u> /script (mail order)/\$140 maximum <u>copay</u> /script (mail order). <u>Deductible</u> does not apply.	20% <u>coinsurance</u> (retail and mail order); \$20 minimum <u>copay</u> /script (retail)/\$70 maximum <u>copay</u> /script (retail); \$40 minimum <u>copay</u> /script (mail order)/\$140 maximum <u>copay</u> /script (mail order). <u>Deductible</u> does not apply.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> (retail and mail order); \$20 minimum <u>copay/script</u> (retail)/\$70 maximum <u>copay/script</u> (retail); \$40 minimum <u>copay/script</u> (mail order)/\$140 maximum <u>copay/script</u> (mail order). <u>Deductible</u> does not apply.	Not covered	Must be purchased through Express Scripts.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$200 <u>deductible</u>	20% <u>coinsurance</u> after \$200 <u>deductible</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you use an <u>out-of-network</u> urgent care center for <u>emergency room services</u> , you might receive a bill from the <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance-billing</u>).
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient <u>out-of-network services</u> covered only if there is an emergency (subject to <u>balance billing</u>).
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient <u>out-of-network</u> services covered only if there is an emergency (subject to <u>balance billing</u>).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply to pregnancy-related preventive <u>screenings</u>.</p> <p>Charges related to a surrogate pregnancy, childbirth classes, adoption fees or elective home delivery are not covered.</p> <p>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Must be approved in writing. Must be under the care of a physician and care must be required to avoid hospital confinement.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient <u>out-of-network</u> services covered only if there is an emergency (subject to <u>balance billing</u>).
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient <u>out-of-network</u> services covered only if there is an emergency (subject to <u>balance billing</u>).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Rental or purchase of equipment prescribed by a physician cannot exceed the reasonable and customary purchase price.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Bereavement counseling, pastoral counseling, financial or legal counseling, funeral arrangements, services that are not for the care of the patient, and respite care are not covered. Additional mental health services available outside the hospice benefit.
If your child needs dental or	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
eye care	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .

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 (except to correct injury, congenital defects of newborn children, defects that result from surgery for which benefits were paid by the plan, and reconstructive surgery after mastectomy)
- Dental care (Adult and Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care (except foot orthotics)
- Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (up to 24 visits per year)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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: contact the Plan at 952-854-0795. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Minnesota Department of Commerce at 651-539-1600 or 800-657-3602 or <http://mn.gov/commerce>.

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 952-854-0795.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$2,000
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$2,300

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$1,190
What isn't covered	
Limits or exclusions	\$160
The total Joe would pay is	\$1,690

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$210
<u>Coinsurance</u>	\$470
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$930

A Health Reimbursement Account (HRA) is also available under this Plan. The HRA generally covers expenses that qualify as allowable "medical care" by the IRS and satisfy any requirements imposed by the plan. Please refer to the SPD for details.

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