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 deductible? | $250 person/$750 family | 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. Preventive care, Doctor on Demand, orthotics (up to $400), and prescription drugs 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? | Yes. $200 person/visit for emergency room services. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Medical: $2,000 (plus $250 deductible) person/$6,000 (plus $750 deductible) family; Prescription Drugs: $4,900 person/$7,550 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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, and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See https://www.bluecrossmn.com/healthy/public/personal/home for a list of 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 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 |
|---|---|---|---|---|
| | | 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% coinsurance | 20% coinsurance | Doctor on Demand telehealth benefits are not subject to the deductible. |
| | Specialist visit | 20% coinsurance | 20% coinsurance | |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | No charge. Deductible does not apply. | There is no charge for age-appropriate preventive services required by the health reform law.<br>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) | 20% coinsurance | 20% coinsurance | Excludes X-rays used for therapeutic treatment. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | None |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at https://www.express-scripts.com/. | Generic drugs | $5 copay/prescription retail; $10 copay/prescription mail order. Deductible does not apply. | $5 copay/prescription retail; $10 copay/prescription mail order. Deductible 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.<br>No charge for ACA-required generic preventive drugs (or brand drug if generic is not medically appropriate).<br>Omnipod DASH and Omnipod 5 covered with preauthorization from Express Scripts. |
| | Preferred brand drugs | 20% coinsurance (retail and mail order); $20 minimum copay/script (retail)/$70 maximum copay/script (retail); $40 minimum copay/script (mail order)/$140 maximum copay/script (mail order). Deductible does not apply. | 20% coinsurance (retail and mail order); $20 minimum copay/script (retail)/$70 maximum copay/script (retail); $40 minimum copay/script (mail order)/$140 maximum copay/script (mail order). Deductible 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) | |
| | Non-preferred brand drugs | 20% coinsurance (retail and mail order); $20 minimum copay/script (retail)/$70 maximum copay/script (retail); $40 minimum copay/script (mail order)/$140 maximum copay/script (mail order). Deductible does not apply. | 20% coinsurance (retail and mail order); $20 minimum copay/script (retail)/$70 maximum copay/script (retail); $40 minimum copay/script (mail order)/$140 maximum copay/script (mail order). Deductible does not apply. | |
| | Specialty drugs | 20% coinsurance (retail and mail order); $20 minimum copay/script (retail)/$70 maximum copay/script (retail); $40 minimum copay/script (mail order)/$140 maximum copay/script (mail order). Deductible does not apply. | Not covered | Must be purchased through Express Scripts. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 20% coinsurance after $200 deductible | 20% coinsurance after $200 deductible | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | 20% coinsurance | 20% coinsurance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | Inpatient out-of-network services covered only if there is an emergency medical condition. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | |
| | Outpatient services | 20% coinsurance | 20% coinsurance | None |

| 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 need mental health, behavioral health, or substance abuse services | Inpatient services | 20% coinsurance | 20% coinsurance | Inpatient out-of-network services covered only if there is an emergency medical condition. |
| If you are pregnant | Office visits | 20% coinsurance | 20% coinsurance | Cost sharing does not apply to pregnancy-related preventive screenings.<br>Charges related to a surrogate pregnancy, childbirth classes, adoption fees or elective home delivery are not covered.<br>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 20% coinsurance | Must be approved in writing. Must be under the care of a physician and care must be required to avoid hospital confinement. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Inpatient out-of-network services covered only if there is an emergency medical condition |
| | Habilitation services | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Inpatient out-of-network services covered only if there is an emergency medical condition. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Rental or purchase of equipment prescribed by a physician cannot exceed the reasonable and customary purchase price. |

| 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) | |
| | Hospice services | 20% coinsurance | 20% coinsurance | 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 eye care | Children's eye exam | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Children's glasses | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Children's dental check-up | Not covered | Not covered | You must pay 100% of this service, even in-network. |

## 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 plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 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 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $30 |
| Coinsurance | $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 plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 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 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $90 |
| Coinsurance | $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 plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 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 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $210 |
| Coinsurance | $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.