




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, including a copy of your plan's summary plan description, go to www.speiasc.org. 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.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$750 person / \$1,500 family for each network and non-network providers.	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 for how much you pay for covered services after you meet the deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care services , Prescription Drugs, Allergy testing, Durable Medical Equipment and certain Transplants are covered before you meet your deductible, if provided by a Network Provider.	This plan covers some items and services even if you haven't yet met the annual 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	Network Medical: \$1,500 person / \$3,000 family; Non-Network Medical \$3,000 person / \$6,000 family. Prescription Out-of-Pocket Limit: \$5,650 person / \$11,300 family	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, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.bluecrossmnonline.com or call 1-800-810-2583 for help in locating a network provider.	This plan uses a network provider. You will pay less if you use a provider in the plan's network. You will pay more if you use an out-of-network provider , and you might receive a bill from the out-of-network provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). For out-of-network charges, the Plan's Allowed Amount is set at the lesser of the amount billed or 175% of Medicare Like Rates. Check with your provider before you get services.
Do you need a referral to	No. you don't need a referral to see	You can see the specialist you choose without permission from this plan.

see a [specialist](#)?

a [specialist](#)

 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 ; No charge for Doctor on Demand telehealth visits	40% coinsurance	Acupuncture must be provided by chiropractor of licensed Acupuncturist; limited to treatment for chronic pain and nausea associated with surgery, chemotherapy, or pregnancy. Maximum of 26 visits per year for chiropractic and acupuncture care.
	Specialist visit	20% coinsurance	40% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	For a pregnancy, two ultrasounds are covered 100% as preventive care; additional ultrasounds may be subject to coinsurance. Includes one diagnostic breast cancer mammogram, if medically necessary, per year at no charge (in addition to one breast cancer screening mammogram per year); additional breast cancer mammograms are subject to coinsurance .

* For more information about limitations and exceptions, see the plan or policy document at www.speiasc.org.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Formulary Drugs	Greater of \$8 (retail 31-day) copay or 20%. Or, \$16 (mail order/ retail 90-day) copay or 20%	Greater of \$8 copay or 20% plus difference between negotiated rate and charge per drug (retail)	Covers up to a 31-day supply (retail); 31-90- day supply (mail order/retail). Copay capped at \$100 (retail/31 day) / \$200 (mail order/retail 90-day) per drug. No coverage for non-network mail-order prescriptions. May be subject to Prior Authorization, Step Therapy and Quantity Limits. Dispensed through the Classic Pharmacy network – go to www.myprime.com
	Non-Formulary Drugs	No coverage	No coverage	-----none-----
	Prescribed PPI/NSAH Over-The-Counter (OTC Drugs)	No charge	No coverage	-----none-----
	Specialty drugs	Greater of \$8 (retail 31-day) copay or 20%. Or, \$16 (mail order/ retail 90-day) copay or 20%	No coverage	Copay capped at \$100 (retail/31 day) / \$200 (mail/retail 90-day order) per drug. Not subject to out-of-pocket limit .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$100 copay per visit & 20% coinsurance	\$100 copay per visit & 20% coinsurance	Copay is not charged if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	-----none-----
	Urgent care	20% coinsurance	40% coinsurance ; No charge for Doctor on Demand telehealth visits	Doctor on Demand telehealth services available at \$0 copayment at www.doctorondemand.com
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Private rooms covered only if medically necessary.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Services must be provided by agencies meeting certain qualifications. See plan for additional requirements and exceptions.
	Inpatient services	20% coinsurance	40% coinsurance	Services must be provided by agencies meeting certain qualifications. See plan for additional requirements and exceptions.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply to certain preventive services. Two ultrasounds are covered 100% as preventive care ; additional ultrasounds are subject to coinsurance .

* For more information about limitations and exceptions, see the plan or policy document at [www.speiasc.org](#).

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)	
				Depending on the type of services or lab work, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Prior authorization required. Services must be provided by a Medicare-certified home health agency. See plan for additional requirements and exceptions.
	Rehabilitation services	20% coinsurance	40% coinsurance	Excludes activities of daily living. Prior authorization required after 26 visits.
	Habilitation services	20% coinsurance	40% coinsurance	Excludes activities of daily living. Prior authorization required after 26 visits.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization required. Confinement must begin within 30 days of discharge from hospital for same or related illness.
	Durable medical equipment	20% coinsurance , no deductible	20% coinsurance , no deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	No coverage	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	Plan provides \$200 allowance per year, otherwise no coverage.	Limited to one exam per year. Benefit provided through Vision Service Plan, www.vsp.com . or 800-877-7195.
	Children's glasses	No charge for lenses, \$150 allowance or frames of choice, or \$170 allowance for featured frame brands, or \$80 allowance for Costco frames.	\$200 allowance per year, otherwise no coverage.	20% off the amount over allowance for frames. Benefit provided through Vision Service Plan, www.vsp.com or 800-877-7195.
	Children's dental check-up	No Charge	Coverage is capped at In-network Allowed Amount, so there may be a balance bill.	Go to www.deltadentalmn.org for a list of participating providers.

* For more information about limitations and exceptions, see the plan or policy document at www.speiasc.org.

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](#).)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-Formulary Drugs
- Private-duty nursing
- Retail Weight loss programs

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

- Acupuncture (limited to treatment for chronic pain And nausea associated with surgery, chemotherapy or pregnancy)
- Bariatric surgery
- Chiropractic care
- Dental care (Adult) (through Dental Care Benefits Plan)
- Hearing aids
- Wigs for chemotherapy patients (lifetime max of \$1400)
- Most coverage provided outside the United States. See www.bluelinktpamn.com
- Routine eye care (Adult) (through Vision Service Plan)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: 1-651-776-4239 or www.speiacs.org.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-811-6086.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-811-6086.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-811-6086.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-811-6086.

Hmong (Hmong): Kev pab nyob rau hauv Hmong, thov hu rau: 1-866-811-6086.

Somali (Soomaali): Wixii caawimaad ah ee Soomaaliya, fadlan wac: 1-866-811-6086.

————— *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	\$750
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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	\$1,500
Copayments	\$0
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$750
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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	\$750
Copayments	\$700
Coinsurance	\$235
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,685

Mia's Simple Fracture

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

■ The plan's overall deductible	\$750
■ Specialist [<i>cost sharing</i>]	20%
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	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	\$750
Copayments	\$100
Coinsurance	\$390
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,240

Note: The "Peg is Having a Baby" Example assumes mother and child each have separate Medical/Pharmacy cost-sharing and OOP limits. The Example assumes Peg gave birth to one child with limited pharmacy. The Diabetes Example assumes that Joe is receiving some medical care, but mostly pharmacy benefits, implicating medical OOP and pharmacy OOP. The Simple Fracture Example assumes only medical care occurred with no pharmacy, so the care is capped by the medical OOP. THESE ARE EXAMPLES ONLY; YOUR FACT SITUATION MAY BE DIFFERENT.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.